PATIENT CONFIDENTAL MEDICAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH_____
TODAY'S DATE_____

Although dental personnel treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationships with the dentistry that you will be receiving.

Thank you for answering the following questions:

Reason for today's visit_____
Where is pain now_____
Name of previous dentist_____
Date of last dental check up_____

1. My general health is: Excellent Good Fair/Poor
2. Name of Physician_____
3. Date of last physical_____
4. Women: Are you pregnant YES NO
   Due Date_____
   Breast Feeding YES NO
   Obstetrician_____
   Last Check-up_____
5. Are you under the care of a physician YES NO
6. Have you ever been hospitalized for any surgical operation or serious illness YES NO
7. If yes, explain:

_____
_____

8. Do you bruise easily YES NO
9. Have you ever required a blood transfusion YES NO
10. Have you had a recent weight loss YES NO
11. Have you or are you currently using tobacco YES NO
12. Do you or have you used controlled substances YES NO
13. Are you wearing contact lenses YES NO
14. Do you have a persistent cough or throat clearing YES NO
15. Do you have any disease, condition, or problem not listed above YES NO

Please list below medications you are currently taking:

_____
_____
_____
_____

Do you have or have you ever had the following:

Heart Disease	YES	NO	Sinus Trouble	YES	NO
Heart Attack	YES	NO	Persistent Cough	YES	NO
Angina	YES	NO	Epilepsy or Seizures	YES	NO
Artificial Heart Valve	YES	NO	Anemia	YES	NO
Heart Surgery	YES	NO	Diabetes	YES	NO
Congenital Heart Problems	YES	NO	Eating Disorders	YES	NO
Stents	YES	NO	Hypoglycemia	YES	NO
Mitral Valve Prolapse	YES	NO	Thyroid Problems	YES	NO
Heart Murmur	YES	NO	Stomach Ulcer	YES	NO
Pace Maker	YES	NO	Kidney Trouble	YES	NO
Rheumatic Heart Disease	YES	NO	Tumors	YES	NO
Aids, HIV Infection	YES	NO	Mental Health Care	YES	NO
Hepatitis	YES	NO	Back Problems	YES	NO
Liver Disease	YES	NO	Hives or Skin Rash	YES	NO
Artificial Joints	YES	NO	Fainting or dizzy spells	YES	NO
Swelling of Feet, Ankles, Hands	YES	NO	Chemical Dependency	YES	NO
Cancer (Chemotherapy, Leukemia)	YES	NO	High Blood Pressure	YES	NO
Glaucoma	YES	NO	Low Blood Pressure	YES	NO
Tuberculosis	YES	NO	Sleep Apnea	YES	NO
Chest Pain	YES	NO			
Blood Thinners (Coumadin, aspirin)	YES	NO	**Are you allergic to or have you had reactions to:**		
Sexually Transmitted Disease	YES	NO	Latex or rubber	YES	NO
Rheumatic Fever	YES	NO	Penicillin	YES	NO
Scarlet Fever	YES	NO	Erythromycin	YES	NO
Asthma	YES	NO	Codeine	YES	NO
Eye/Ear Problems	YES	NO	Aspirin	YES	NO
Lung or Breathing Problems	YES	NO	Local Anesthetic	YES	NO
COPD	YES	NO	Other:_____		

Dental Evaluation:

Orthodontics	YES	NO
Oral Surgery	YES	NO
Gum Treatment	YES	NO
Clicking of the Jaw	YES	NO
Jaw Joint Pain	YES	NO
Difficulty Opening/Closing	YES	NO
In general are you pleased with overall appearance of you smile/teeth?	YES	NO
Do you like the color of your teeth?	YES	NO
Worn a bite plate/appliance	YES	NO
Clenching or Grinding of your teeth while awake or asleep	YES	NO
Do you like the position of your teeth?	YES	NO
Do you have old fillings that you don't like looking at?	YES	NO
Do you like the shape of your teeth?	YES	NO

If you could change anything about your teeth, what would it be?_____