

## PATIENT'S MEDICAL HISTORY

Yes    No

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in good health?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you under a physician's care?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you subject to prolonged bleeding?                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had major surgery?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been hospitalized in the last five years?                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? What month? _____                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have or been told you had TMJ(temporo-mandibular joint) syndrome? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for TMJ?                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your jaws ever lock?  |
|                          |                          | Are you allergic or had an unusual reaction to.....                      |
| <input type="checkbox"/> | <input type="checkbox"/> | penicillin   |
| <input type="checkbox"/> | <input type="checkbox"/> | novocaine  |
| <input type="checkbox"/> | <input type="checkbox"/> | aspirin  |
| <input type="checkbox"/> | <input type="checkbox"/> | codiene  |
| <input type="checkbox"/> | <input type="checkbox"/> | valium   |
| <input type="checkbox"/> | <input type="checkbox"/> | barbiturates   |
| <input type="checkbox"/> | <input type="checkbox"/> | demerol  |
| <input type="checkbox"/> | <input type="checkbox"/> | nitrous oxide  |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking any medications now?                                      |
|                          |                          | List them _____  |
|                          |                          | _____  |
|                          |                          | _____  |
|                          |                          | _____  |

Check any of the following which you have had or presently have...

- |                             |                          |
|-----------------------------|--------------------------|
| Aids or A/R/C               | <input type="checkbox"/> |
| Heart Condition             | <input type="checkbox"/> |
| Heart Pacemaker             | <input type="checkbox"/> |
| Heart Angina                | <input type="checkbox"/> |
| Heart Attack (coronary)     | <input type="checkbox"/> |
| Heart Murmur                | <input type="checkbox"/> |
| Congenital Heart Disease    | <input type="checkbox"/> |
| Heart Surgery               | <input type="checkbox"/> |
| Rheumatic Fever             | <input type="checkbox"/> |
| Diabetes                    | <input type="checkbox"/> |
| Hepatitis                   | <input type="checkbox"/> |
| Ulcers                      | <input type="checkbox"/> |
| Stroke                      | <input type="checkbox"/> |
| Anemia                      | <input type="checkbox"/> |
| Asthma                      | <input type="checkbox"/> |
| Epilepsy                    | <input type="checkbox"/> |
| Glaucoma                    | <input type="checkbox"/> |
| Tuberculosis                | <input type="checkbox"/> |
| Venereal Disease            | <input type="checkbox"/> |
| Herpes                      | <input type="checkbox"/> |
| Fainting Spells             | <input type="checkbox"/> |
| Kidney Trouble              | <input type="checkbox"/> |
| Radiation Therapy           | <input type="checkbox"/> |
| Psychiatric Treatment       | <input type="checkbox"/> |
| Blood Disorders             | <input type="checkbox"/> |
| Respiratory or Lung Disease | <input type="checkbox"/> |
| High Blood Pressure         | <input type="checkbox"/> |
- any other health Problems? \_\_\_\_\_

### RECENT DENTAL HISTORY

(please check appropriate boxes)

**I am here for treatment of:**

- present pain     past pain     abscess

**My dentist said I need:**

- root canal     consultation     other (please describe) \_\_\_\_\_

**For my problem I am presently taking:**

- antibiotics     pain pills     other \_\_\_\_\_

Signature of Patient or (parent/guardian of minor) \_\_\_\_\_ Date \_\_\_\_\_