## MEDICAL HISTORY

Today's Date: _____

Patient Name: _____ _____
Last First and Middle

Date of Birth: _____/_____/_____

***Answers all questions and provide any information needed for "yes" answers***

| | Yes | No |
|---|---|---|
| Do you have active TB (tuberculosis), exposure to TB, persistent cough, or cough producing blood? | ☐ | ☐ |
| Are you now or have been under the care of a physician?<br>If yes, for what? _____ | ☐ | ☐ |
| Have you had any serious illness, operations, or have been hospitalized in the past 5 years?<br>If yes, list: _____ | ☐ | ☐ |
| Are you scheduled to take? Or, do you/ have you taken Phen-Fen or Redux? If yes, When _____ | ☐ | ☐ |
| Are you on a special diet? If yes, what diet? _____ | ☐ | ☐ |
| Do you have **ALLERGIES** to food, medication, or anything else? If yes, list allergies: _____ | ☐ | ☐ |
| Have you taken or currently taking **Steroids** (like Cortisone) in the last 2 years? If yes, list when and what kind: _____ | ☐ | ☐ |
| Have you taken, currently taking, or scheduled to begin taking: **oral or intravenous bisphosphonates**?<br>**Oral**: (Alendronate, Fosamax, Fosamax Plus D, Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), or Tiludronate (Skedil)).<br>**Intravenous**: (Clodronate (Bonefos), Pamifronate (Aredia) or Zoledronic Acid (Reclast, Zometa)) | ☐ | ☐ |
| Have you had:<br>Open Heart Surgery ☐ Endocarditis ☐ Mitral Valve Prolapse ☐ Artificial Heart Valve ☐ Organ Transplant ☐ | ☐ | ☐ |
| Are you on **BLOOD THINNERS (Which one(s)):** _____ **or do you take aspirin?** | ☐ | ☐ |
| Have you undergone Radiation Therapy or Chemotherapy for a growth, tumor, or any other condition?<br>If yes, explain: _____ | ☐ | ☐ |
| Do you have an **artificial joint**? (example Knee) Which joint(s): _____ When: _____ | ☐ | ☐ |
| Have you ever been told that you need to be **pre-medicated (take an antibiotic) for a dental appointment**? | ☐ | ☐ |

***Please check all that apply:***

Have you fallen or almost fallen in the past three (3) months? ☐ Have a fear of falling? ☐
Do you have difficulty walking ☐ moving around ☐ an assistive device ☐
(Circle all that apply: cane, walker, wheelchair, crutches, or artificial limb) None

**Females**: Pregnant ☐ Nursing ☐ Taking Birth control pills ☐ fertility drugs ☐, hormone replacement ☐
If pregnant, trimester _____ and due date _____

Tobacco use: Never ☐ Past ☐ Current ☐ Types: Cigarettes ☐ Cigars ☐ Pipe ☐

eCigarettes/Vaping: Never ☐ Past ☐ Current ☐ If current user: Type: Disposable ☐ Pre-filled or Refillable ☐
Nicotine ☐ THC ☐ CBD ☐

Alcohol use: Never ☐ Past ☐ Current ☐ Drinks per week: _____
Do you use or have you used prescription or street drugs or other substances for recreational purposes? Never ☐ Past ☐ Current ☐

**Do you have or have you ever had any of the following** (circle Yes or No, or leave blank if uncertain)

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| AIDS or HIV Positive | ☐ | ☐ | Anemia | ☐ | ☐ | Arthritis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Back Trouble | ☐ | ☐ | Bladder Infection | ☐ | ☐ |
| Bleeding Tendency | ☐ | ☐ | Bronchitis | ☐ | ☐ | Cancer or Tumors | ☐ | ☐ |
| Chickenpox | ☐ | ☐ | Diabetes | ☐ | ☐ | Diphtheria | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Glaucoma | ☐ | ☐ | Heart Disease | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ | Hepatitis | ☐ | ☐ | Hernia | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Hives or Eczema | ☐ | ☐ |
| Infectious Mononucleosis | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Measles | ☐ | ☐ |
| Pneumonia | ☐ | ☐ | Stroke | ☐ | ☐ | Mumps | ☐ | ☐ |
| Migraines | ☐ | ☐ | Ulcer | ☐ | ☐ | Blurred Vision | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | Polio | ☐ | ☐ | Other: | ☐ | ☐ |
| Venereal Disease | ☐ | ☐ | Small Pox | ☐ | ☐ | _____ | ☐ | ☐ |
| Transfusions | ☐ | ☐ | Whooping Cough | ☐ | ☐ | _____ | ☐ | ☐ |
| Gerd | ☐ | ☐ | Scarlet Fever | ☐ | ☐ | _____ | ☐ | ☐ |
| Eating Disorder | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | _____ | ☐ | ☐ |

Any other disease please specify here: _____

If yes to any of the above questions explain: _____

| Surgeries | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

List of medications, including OTC (over-the-counter), diet supplements, vitamins (natural or herbal) currently taking or have taken in the last month:

| Name of Medication or product | Dosage | Times per day | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

# Review of Systems / Patient's Past Medical History

(Circle all that currently apply):

GENERAL

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Fever or Chills | Night Sweats | Weight loss | Weight Gain | Fatigue | Cold or Heat intolerance | | | | |

ENT

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Eyes**: Blurred vision | Double vision | Pain | itching | Watering | | | |
| **Ears** / **Nose** / **Throat**: | Ringing in ears / Decreased Hearing | Ear pain or drainage | Running nose | Congestions | Sneezing | Sore throat | swallowing difficulty |

GASTROINTESTINAL

| | | | | | | |
|---|---|---|---|---|---|---|
| Abdominal pain / Bloating | Belching / Gas | Heartburn | Constipation | Diarrhea | Bloody or Tarry Stool | |
| Change in stool / Consistency of stool (liquid / soft / hard) | Frequency (daily / every other day / biweekly / weekly) | | # of stools per day _____ | | | |

CARDIOVASCULAR:

| | | | | | | |
|---|---|---|---|---|---|---|
| Chest pain (resting or with exertion) | Palpitations (Heart beats fast or funny) | Swelling | Swollen ankles | | | |
| Leg pain when walking | Fainting or Blacking out | High Blood Pressure | | | | |

RESPIRATORY:

| | | | | | | |
|---|---|---|---|---|---|---|
| Cough (day or night) | Shortness of Breath (rest or with exertion | sputum | and history of asthma / wheezing | bronchitis | pneumonia | |

GENITOURINARY:

| | | | | | |
|---|---|---|---|---|---|
| Urination (frequency of urination /) | History of kidney stones | Sexually transmitted diseases | Urinary Tract Infections | Multiple sex partners: yes/no | painful urination / bloody urine |

MUSCULOSKELETAL:

| | | | | | | |
|---|---|---|---|---|---|---|
| Pain or swelling in muscles or joints | weakness | Arthritis | Osteoporosis | Bone fracture / joint injury | Gout | |

HEM / LYMPH:

| | | | | | | |
|---|---|---|---|---|---|---|
| Easy Bleeding or bruising | Lumps or bumps in neck | armpits | groin | breasts or testicles. | | |

NEUROLOGICAL:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Numbness and Tingling | Fainting | Blackouts | Abnormal Jerking | Repetitious movements | history of seizures | tremors | tics | |

SKIN:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Acne | Dry | Flaky | Peeling | Rash | Redness | Itchy | |
| Recent change in moles/lesions/or birthmarks. | | Eczema, cellulitis | | | | | |

Describe color / location /size:_____

PSYCHIATRIC:

| | | | | | | |
|---|---|---|---|---|---|---|
| Anxiety | crying episodes | depression | moodiness | paranoia | or phobias | |
| | | | | | | |

# Dental History

**Do you experience or do you have or had:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Dental pain – If yes, rate from 1-10: 7<br>Details: _____ | ☐ | ☐ | Do you think you have active tooth decay or gum disease? | ☐ | ☐ |
| | | | Gum treatment or gum surgery<br>If yes, when and where:_____ | ☐ | ☐ |
| Difficulty opening your mouth | ☐ | ☐ | Tongue or lip piercing | ☐ | ☐ |
| Difficulty Chewing | ☐ | ☐ | Ever worn or currently wear braces? If yes, do you wear: | ☐ | ☐ |
| Jaw click, pop, or lock open (circle all that apply) | ☐ | ☐ | Orthodontic Retainer | ☐ | ☐ |
| History of sores, ulcers, or growths in your mouth | ☐ | ☐ | Athletic guard or night guard | ☐ | ☐ |
| Clench or grind your teeth | ☐ | ☐ | Do you have crowns or bridges? | ☐ | ☐ |
| Dry mouth | ☐ | ☐ | Do you have any removable partial denture or full denture? How old are they_____<br>If yes, are you happy with them | ☐ | ☐ |
| Teeth sensitive to hot or cold, sweets or pressure | ☐ | ☐ | | ☐ | ☐ |
| Gums bleed when brushing or flossing | ☐ | ☐ | Previous dentist Name_____ | ☐ | ☐ |
| Do you consider yourself to have dental anxiety?<br>Explain: _____ | ☐ | ☐ | Last Full mouth xrays - Date taken _____ | ☐ | ☐ |
| Ever had a serious injury to your head or mouth?<br>Explain: _____ | ☐ | ☐ | | ☐ | ☐ |
| Any issues with numbing:<br>Explain: _____ | ☐ | ☐ | Root Canals | ☐ | ☐ |
| Date of last exam/cleaning _____ | ☐ | ☐ | Swelling in or around your mouth, face, or neck<br>Where: _____ | ☐ | ☐ |
| Brush your teeth: How often _____ | ☐ | ☐ | Extensive dental therapy (such as Implants, TMJ surgery, cosmetic procedures)<br>If yes, Explain _____ | ☐ | ☐ |
| Floss your teeth: How often _____<br>If No, why _____ | ☐ | ☐ | Have you been diagnosed with TMD? | ☐ | ☐ |
| | | | | | |
| | | | | | |