MEDICAL HISTORY

Patient's name

_____ _____ _____

Medical Doctor's Name Address Phone

_____

Date of My Last Physical Examination

_____

Are you being treated by a medical doctor now? If yes, for what reason?

_____

Are you taking any medicine at the present time? If yes, what?

_____

Are you sensitive or allergic to any medicine? If yes, what?

_____

Have you ever been hospitalized or had any surgical operations? If yes, list reasons and dates

_____

Have you ever had any blood transfusions? If yes, give reason

Have you had:

□ Yes	□No	HIV Positive	□ Yes	□No	High Blood Pressure
□ Yes	□No	Gall Bladder Disease	□ Yes	□No	AIDS
□ Yes	□No	Low Blood Pressure	□ Yes	□No	Diabetes (Sugar Disease)
□ Yes	□No	Asthma	□ Yes	□No	Stroke
□ Yes	□No	Nervousness	□ Yes	□No	Hay Fever
□ Yes	□No	Anemia	□ Yes	□No	Epilepsy or Seizures
□ Yes	□No	Tuberculosis	□ Yes	□No	Allergies or Hives
□ Yes	□No	Fainting or Dizzy Spells	□ Yes	□No	Rheumatic Fever
□ Yes	□No	Ulcers (stomach or intestinal)	□ Yes	□No	Pacemaker
□ Yes	□No	Scarlet Fever	□ Yes	□No	Arthritis
□ Yes	□No	Thyroid Disease (or Goiter)	□ Yes	□No	Heart Murmur
□ Yes	□No	Venereal Disease	□ Yes	□No	X-Ray or Cobalt Treatment
		(Syphilis or Gonorrhea)	□ Yes	□No	Heart Disease
□ Yes	□No	Psychiatric Treatment	□ Yes	□No	Angina Pectoris
□ Yes	□No	Kidney Disease	□ Yes	□No	Chemotherapy
□ Yes	□No	Hepatitis			(Cancer, Leukemia)
□ Yes	□No	Bladder Disease	□ Yes	□No	Osteoporosis or Osteopenia

Do you have any disease, condition or problem not listed above?
If yes, explain: _____

_____

Females

□ Yes □No Are you pregnant? (Date of delivery _____)

□ Yes □No Are you taking oral contraceptives (Birth control pills?)

Dental History

□ Yes □No Have you had any serious trouble associated with any previous dental treatment?
If yes, explain: _____

□ Yes □No Have you recently had dental x-rays? If yes, when:_____

□ Yes □No Have you had undesirable reaction to local or general anesthetics
(For example, Novocain or Gas)

□ Yes □No Do you clench or grind your teeth?

□ Yes □No Are any of your teeth sensitive to cold or sweets?

□ Yes □No Are you dissatisfied with the appearance of your teeth?

□ Yes □No Have you had excessive swelling or pain after oral surgery?

□ Yes □No Have your teeth been cleaned recently?

□ Yes □No Do you have bleeding gums?

□ Yes □No Do you have a bad taste in your mouth?

□ Yes □No Does food pack between your teeth?

□ Yes □No Does your jaw click or pop when you chew?

□ Yes □No Have you ever received treatment for periodontal disease?

What is your chief complaint concerning your mouth or teeth?_____
_____

To the best of my knowledge all of the above answers are true and correct. If I have any change in my health, I will inform Dr. Schweinebraten or Dr. McFarland at my next appointment.

_____ _____

Signature of Patient Date