



MEDICAL HISTORY

Name _____ Date of Birth _____ Date _____

Address _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Have you ever had an unusual reaction to drug, anesthetic or latex? YES NO

If yes, please explain _____

Are you presently under the care of a physician or therapist? YES NO

Physician's name _____ City _____ Last exam _____ Phone# _____

Have you ever had surgery or been hospitalized for any reason? YES NO

Please list reason and year _____

Are you deaf or hard-of-hearing? YES NO If yes, do you lip-read? Sign? Which do you prefer? _____

Are you pregnant? YES NO

Have you taken any medication for osteoporosis or osteopenia? YES NO

If yes, what medication, dose, when, and for how long? _____

Have you noticed any changes in your mouth? YES NO Please explain: _____

Do you have any sore spots or lumps in your mouth? YES NO _____

Do you have a persistent cough? YES NO _____

Are there areas that food gets caught between your teeth? YES NO _____

Do your gums bleed? YES NO If yes, when do they bleed? _____

Is there anything you would change about your smile? YES NO _____

Does your jaw click or pop? YES NO If yes, when? _____

Do you have any soreness in the muscles of your face or ear? YES NO _____

Do you clench or grind your teeth? YES NO _____

Do you snore? YES NO

Have you been told that you choke or gasp during sleep? YES NO

Are you likely to fall asleep when sitting quietly during the day? YES NO

Have you ever had a sleep study? YES NO If yes, year and diagnosis: _____

Name _____ Date _____

Do you take any medications or supplements? YES NO

If yes, please list medications or supplements you are presently taking and why

Drug _____ Condition _____

Drug _____ Condition _____

Drug _____ Condition _____

Do you have, or have you ever had, any of the following conditions?

(Please X each appropriate box):

	Yes	No		Yes	No		Yes	No
Heart Trouble / Stroke			Herpes or HPV			Anemia/Sickle Cell		
Angina/ Chest Pain			Venereal Disease			Tuberculosis		
High Blood Pressure			HIV Positive			Immunodeficiency		
Low Blood Pressure			AIDS or ARC			Bleeding Problems		
Circulatory Problem			Hepatitis			Seizures / Epilepsy		
Heart Murmur			Liver Disorder			Psychiatric care		
Heart Pacemaker			Kidney Disorder			Endocarditis/Bacteremia		
Artificial Valve			Diabetes			Dry Mouth		
Rheumatic Fever			Hormone Imbalance			Asthma		
Cancer			Thyroid Problems			Emphysema		
Radiation Treatment/Chemo			Acid Reflux / GERD			Stomach/ Intestinal		
Artificial Joint			Eating Disorder			Ulcers		
Arthritis/ Rheumatoid			Glaucoma			Sinus Problems		
Autoimmune Disease			Stroke			Cochlear Implant		
Sjogren's			Lupus			Other		
Have You Used Recreational Drugs			Smoked or Used Tobacco?			Do You Drink Alcohol?		

If you have answered yes to any of the above, please explain.

(Please include year of diagnosis if applicable. Use other side if needed): _____

Is there any other information about your health not covered above? _____

