MEDICAL HISTORY

Are you currently under a physician's care? ________ YES ________ NO

For what? ____________________

Current medications ____________________

When was your last complete physical examination? ____________________

Nutritional Supplements: ____________________

Daily Aspirin/Ibuprofen ________ YES ________ NO

Have you been hospitalized in the past 2 years? ______ YES ______ NO For What? ____________________

DO YOU HAVE OR HAVE YOU EVER HAD:

CARDIOVASCULAR	Yes	No	?
Any heart problems			
Rheumatic fever			
Pacemaker			
Mitral valve prolapse			
Heart septal defect			
Heart murmur			
High blood pressure			
Low blood pressure			
Circulatory problems			
Excessive bleeding			
Anemia			
Stroke			
Shortness of breath			
Chest pains/Angina			
Swelling in ankles			
Blood Thinners			
Blood disorders			
Coronary Artery Disease			
Bruise easily			
Other____________			
INFECTIOUS			
Tuberculosis			
Venereal disease			
HIV			
Other____________			

BONE-JOINT	Yes	No	?
Arthritis			
Osteopenia/Osteoporosis			
Prosthetic Joint			
TMJ			
Other____________			
ENDOCRINE GENTIO-URINARY			
Diabetes			
Kidney disease			
Thyroid problems			
Prostate problems			
Other____________			
ALLERGY-RESPIRATORY			
Sinus problems			
Asthma/Hay fever			
Emphysema			
Persistent cough			
Allergy to drugs			
Allergy to anesthetics			
Allergy to latex			
Other____________			
FEMALE			
Pregnant			
Birth control			
Hormone therapy			
Post-menopause			

NERVOUS SYSTEM	Yes	No	?
Nervous problems			
Psychiatric care			
Psychological care			
Frequent headaches			
Epilepsy			
Other____________			
TUMOR-GROWTHS			
Benign tumors			
Malignancies			
Radiation treatment			
Chemotherapy			
Other____________			
EYES			
Dryness			
Other____________			
GASTROINTESTINAL			
Ulcers			
Colitis			
Hepatitis/Contact			
Jaundice			
Irritable bowel			
Other____________			

Blood pressure ________ / ________

SOCIAL HISTORY

Smoker? ________YES ________NO

Alcoholism? ________YES ________NO

Recreational drug use? ________YES ________NO

Nerve or sleep medication? ________YES ________NO

Under unusual stress? ________YES ________NO

Recent weight changer? ________YES ________NO

DENTAL HISTORY

How long have you been a patient of your current dentist? ____________________

When was your last dental cleaning (periodontal maintenance)? ____________________

Number of cleanings in the past three years? ____________________

Previous treatment? ____________ Periodontal ____________ Orthodontics