MEDICAL HISTORY

Physician ____ Date of Last Visit ______________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ____
Yes No Do you have a history of a major illness? ____
Yes No Have you had any operations? ____
Yes No Have you ever been hospitalized for an illness? __________________________________
Yes No Have you seen a physician in the last 12 months? Why? ____________________________
Yes No Have you ever taken any bisphosphonates? When? _________________________________
Yes No Do you have any allergies? To what? ____

For Women:
Yes No Are you pregnant? Due Date? ____
Yes No Are you nursing? ____
Yes No Are you taking oral contraceptives? ____

Please circle yes or no for the following pertaining to your health. Your answers are for our records only and will be confidential.

Anemia or Blood Disorder	No	Yes	Hepatitis? If yes, then what type	No	Yes
Arthritis	No	Yes	High Blood Pressure	No	Yes
Asthma	No	Yes	Low Blood Pressure	No	Yes
Cancer	No	Yes	Liver Disease	No	Yes
Diabetes? If yes, then which Type?	No	Yes	Current or Past Drug Addiction? If yes, please explain below.	No	Yes
Emphysema	No	Yes	Mental Disorders (including depression)? If yes, please explain below.	No	Yes
Epilepsy/Convulsions	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting/Seizures	No	Yes	Rheumatic Fever	No	Yes
Bacterial Endocarditis	No	Yes	Leukemia	No	Yes
Pacemaker	No	Yes	HIV Infection/AIDS	No	Yes
Heart Murmur	No	Yes	Stomach Trouble	No	Yes
Chest Pains	No	Yes	Stroke	No	Yes
Heart Trouble or Heart Disease	No	Yes	Thyroid Problem	No	Yes
Easily Winded	No	Yes	Hay Fever/Allergies	No	Yes
Mitral Valve Prolapse	No	Yes	Respiratory Problems	No	Yes
Tuberculosis	No	Yes	Glaucoma	No	Yes
Joint Replacement	No	Yes	Other		

Please explain any that you answered yes to or any other conditions that were not mentioned above. ____________________
____

DENTAL HISTORY

Previous Dentist ____ Date of last visit ______________________________

What concerns you most about your teeth? ____

Are you presently in any pain?	No	Yes	Do you have frequent headaches?	No	Yes
Are your teeth sensitive to hot or cold?	No	Yes	Do you clench/grind your teeth?	No	Yes
Do your gums bleed when brushing/flossing?	No	Yes	Do you bite your lips/cheeks?	No	Yes
Are your teeth sensitive to sweet?	No	Yes	Have you ever had a bad dental experience?	No	Yes
Do you have any sores/lumps in your mouth?	No	Yes	Have you had any head, neck, jaw injury?	No	Yes
Are you a mouth breather?	No	Yes	Have you had clicking or pain in your jaw?	No	Yes
Do you wear dentures/partials?	No	Yes	Do you like your Smile?	No	Yes

Signature: ____Date: ____________________