CONFIDENTIAL MEDICAL HISTORY

Patient's Name:_______________________________ Birthdate:_____________

Dental History

Check (☑) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking, popping, or pain in jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal (gum) treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths in mouth

Medical History

Physician's Name: _______________________________

Have you ever had any serious illnesses or operations? ☐ yes ☐ no

If yes, describe: _______________________________

(Women) Are you pregnant? ☐ yes ☐ no Nursing? ☐ yes ☐ no Taking birth control? ☐ yes ☐ no

Check (☑) if you have or have had any of the following:

- ☐ AIDS/HIV positive
- ☐ Alzheimer's Disease/Dementia
- ☐ Anxiety/Depression
- ☐ Artificial Heart Valve
- ☐ Artificial Joint (date placed?_______)
- ☐ Bone loss/Osteoporosis
- ☐ Breathing problem/Asthma
- ☐ Bruise easily
- ☐ Cancer/Chemotherapy/Radiation
- ☐ Cold Sores/Fever Blisters
- ☐ Cortisone medicine
- ☐ CPAP machine
- ☐ Developmental Disabilities
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Excessive bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches
- ☐ Heart Trouble/Disease
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ Kidney Disease/Disorder
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Sinus Trouble
- ☐ STD
- ☐ Stroke
- ☐ Schizophrenia
- ☐ Sleep Apnea/Snoring
- ☐ Tobacco use

Medications

List any medications you are currently taking: _______________________________

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Allergies

- ☐ Acrylic
- ☐ Barbiturates (sleeping pills)
- ☐ **LATEX**
- ☐ Local Anesthetic
- ☐ Metal
- ☐ NSAIDs (Aspirin, Ibuprofen)
- ☐ **PENICILLIN/AMOXICILLIN**
- ☐ Percocet
- ☐ Sulfa
- ☐ Vicodin
- ☐ Other_______________

Signature

To the best of my knowledge, this information is accurate and complete. I understand that it is my responsibility to inform my health care professionals whenever I, or my minor child, have any changes in health.

_______________________________ Signature of Patient, Parent, Guardian, or Legal Representative

_______________ Date