PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last exam _____

	Yes	No
1. Are you under medical treatment now?	□	□
2. Have you ever been hospitalized in the past 5 yrs?	□	□
If yes, Please Explain _____		
3. Are you taking any medications?	□	□
What medications: _____		
(Incluya los no recetados por su Dr.) _____		
4. Have you ever taken Fosamax, Actonel, Boniva?	□	□
5. Do you use Tobacco?	□	□
6. Do you use controlled substances?	□	□
7. Do you wear contact lenses?	□	□
8. Do you have a persistent cough or throat clearing not associated with a known illness (more than three weeks)?	□	□

9. Are you allergic to or have any reactions to the following?	Yes	No
Medication's	□	□
Local Anesthesia (e.g. Novocain)	□	□
Penicillin or any other antibiotics	□	□
Sulfa	□	□
Barbiturates	□	□
Sedatives	□	□
Iodine	□	□
Aspirin	□	□
Any Metals (e.g. nickel, mercury, etc.)	□	□
Latex (Rubber)	□	□
Other (please list) _____		

10. **WOMEN ONLY**

a) Are you pregnant or think you may be pregnant?	□	□
b) Are you nursing?	□	□
c) Are you taking oral contraceptives?	□	□

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure	□	□	Heart Disease	□	□	Chest pains	□	□
Heart attack	□	□	Cardiac Pacemaker	□	□	Easily winded	□	□
Rheumatic fever	□	□	Heart Murmur	□	□	Stroke	□	□
Swollen ankles	□	□	Angina	□	□	Hay fever/allergies	□	□
Fainting/seizures	□	□	frequently tired	□	□	Tuberculosis	□	□
Asthma	□	□	Anemia	□	□	Radiation therapy	□	□
Low blood pressure	□	□	Emphysema	□	□	Glaucoma	□	□
Epilepsy/convulsions	□	□	Cancer	□	□	Recent weight loss	□	□
Leukemia	□	□	Arthritis	□	□	Liver disease	□	□
Diabetes	□	□	Joint replacement or implant	□	□	Heart Trouble	□	□
Kidney disease	□	□	Hepatitis/Jaundice	□	□	Respiratory problems	□	□
AIDS of HIV infection	□	□	Sexually transmitted disease	□	□	Mitral valve prolapsed	□	□
Thyroid problems	□	□	Stomach problems/Ulcers	□	□	Other (Explain) _____		

PATIENT DENTAL HISTORY

Name of your prior Dentist_____ Date of last exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	□	□
2. Are your teeth sensitive to hot or cold liquids/foods?	□	□
3. Are you teeth sensitive to sweet or sour?	□	□
4. Do you feel pain in any of your teeth?	□	□
5. Do you have any sores or lumps in your mouth?	□	□
6. Have you had any head, neck or jaw injuries?	□	□
7. Have you ever experienced any of the following problems with your jaw?		
- Clicking	□	□
- Pain (joint, ear side of face)	□	□
- Difficulty in opening or closing	□	□
- Difficulty in chewing	□	□
8. Do you have frequent headaches?	□	□
9. Do you clinch or grind your teeth?	□	□

	Yes	No
10. Do you bite your lips or cheeks often?	□	□
11. Have you ever had any difficult extractions?	□	□
12. Have you ever had any prolonged bleeding following extractions?	□	□
13. Have you had any orthodontic treatment?	□	□
14. Do you wear dentures or partials?	□	□
If yes, Date of Placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	□	□
16. Do you like your Smile?	□	□