Examination Date _____

Name _____ **DRUG ALLERGIES**:_____

Medical History	***Please Circle***		***Comments/ Notes***
1. Are you in good health? _____	Yes	No	
2. Date of last physical examination _____	Yes	No	
3. Are you being treated by a physician now? ___	Yes	No	
4. Are you taking any prescription medication? __	Yes	No	Please list ***all*** medications
5. Are you taking any over the counter medication?	Yes	No	you are currently taking:
6. Have you had any excessive bleeding requiring special treatment? _____	Yes	No	
7. Have you had surgery within the last 5 years?_ If yes, when and what for? _____	Yes	No	

8. Have you ever had any of the following conditions? (*Please check*)

__Rheumatic Fever	__Diabetes - Self / Family
__Mitral Valve Prolapse	__Liver Disorder
__Hepatitis A – B – C	__Angina
__Heart Murmur	__Heart Valve Replacement/Repair
__Respiratory Disorder	__Tuberculosis
__High Blood Pressure	__Low Blood Pressure
__Stroke	__Arthritis
__Asthma	__Blood Disease
__Blood Transfusion	__Cancer
__Anemia	__Artificial Joint
__Organ Transplant	__Other _____

9. Have you been treated for any type of skin disease?	Yes	No
10. Have you ever taken anti-coagulants (blood thinner)? If so, when and for how long? _____	Yes	No
11. Do you smoke? If yes, how many packs per day ___	Yes	No
12. Do you use smokeless tobacco?_____	Yes	No
13. Women: Are you pregnant? Expected due date___	Yes	No
Have you reached menopause?_____	Yes	No
Do you take birth control pills? _____	Yes	No
14. Are you on a regular exercise program?_____	Yes	No
15. Have you been diagnosed with HIV (AIDS)?_____	Yes	No

Dental History

16. Are you experiencing pain in your mouth at this time?	Yes	No
17. Have you had previous periodontal surgery?_____ If yes, how long ago and where in your mouth?_____ _____	Yes	No
18. Do your gums bleed? _____	Yes	No
19. Have you noticed any loose or shifting teeth?_____	Yes	No
20. Have you noticed any new spaces between your teeth?	Yes	No
21. Have you experienced mouth odor/bad taste in mouth?	Yes	No
22. Are your teeth sensitive to heat, cold or sweets? ___	Yes	No
23. Have you worn braces or Invisiline?_____	Yes	No
24. Do you grind your teeth or wear a night guard?____	Yes	No
25. Do you have clicking, popping or pain in jaw joints?	Yes	No
26. Would you be interested in dental implants? _____	Yes	No
27. What is your recall frequency and last dental visit?_____		

Comments: _____

Patient Signature: _____ Date:_____

MEDICAL/DENTAL HISTORY