Height: Weight:

Smoking Status: (Check one) ☐Current every day smoker ☐Current some day smoker ☐Former Smoker ☐Never smoked ☐Smoker ☐Unknown if ever smoked

If smoker: How much?____________ How long?____________ When quit?____________

Alcohol Use: ☐No ☐Yes Type?______________ How much?__________________

Drugs: ☐No ☐Yes Type?______________ How much?_________ How long?__________ When quit?_____

Pharmacy________________________________ **Phone #**______________________________________

Review of Systems Please comment on any "YES" answers in the space provided below.

Oral			**Respiratory**			**Blood/Lymph nodes**		
Previous Surgery	☐ Yes	☐No	Cough	☐ Yes	☐No	Easy Bruising	☐ Yes	☐No
Dentures	☐ Yes	☐No	Congestion	☐ Yes	☐No	Gums Bleed Easily	☐ Yes	☐No
Pain	☐ Yes	☐No	Wheezing	☐ Yes	☐No	Prolonged Bleeding	☐ Yes	☐No
Bleeding	☐ Yes	☐No	Asthma	☐ Yes	☐No	Heavy Aspirin Use	☐ Yes	☐No
Sore	☐ Yes	☐No						
Chewing Pain	☐ Yes	☐No	**Gastrointestinal**			**Musculoskeletal**		
Jaw Pain	☐ Yes	☐No	Heartburn	☐ Yes	☐No	Stiffness	☐ Yes	☐No
Tooth Loss	☐ Yes	☐No	Nausea/Vomiting	☐ Yes	☐No	Arthritis	☐ Yes	☐No
Cavities	☐ Yes	☐No	Jaundice/Hepatitis	☐ Yes	☐No	Joint Pain/Swelling	☐ Yes	☐No
Gum Disease	☐ Yes	☐No						
Snoring	☐ Yes	☐No	**Genito-Urinary**			**Skin**		
Over/under bite	☐ Yes	☐No	Pain/Difficulty Urinating	☐ Yes	☐No	Rash/Sores	☐ Yes	☐No
			Blood in Urine	☐ Yes	☐No	Lesions	☐ Yes	☐No
Ear Nose and Throat			History of Kidney Stones	☐ Yes	☐No	Hives/Eczema	☐ Yes	☐No
Hard of Hearing	☐ Yes	☐No	History of STD's	☐ Yes	☐No			
Ringing in Ears	☐ Yes	☐No				**Neurological**		
Vertigo	☐ Yes	☐No	**Psychiatric**			Seizures	☐ Yes	☐No
			Anxiety/Depression	☐ Yes	☐No	Weakness/Paralysis	☐ Yes	☐No
Cardiovascular			Mood Swings	☐ Yes	☐No	Numbness	☐ Yes	☐No
Chest Pain	☐ Yes	☐No	Difficulty Sleeping	☐ Yes	☐No	Tremors	☐ Yes	☐No
Dizziness	☐ Yes	☐No						
Fainting Spells	☐ Yes	☐No	**Endocrine**			**Immunologic**		
Shortness of Breath	☐ Yes	☐No	Increased Thirst	☐ Yes	☐No	Hives	☐ Yes	☐No
Irregular Heart Beat	☐ Yes	☐No	Increased Hunger	☐ Yes	☐No	Itching	☐ Yes	☐No
Difficulty Lying Flat	☐ Yes	☐No	Increased Urination	☐ Yes	☐No	Runny Nose	☐ Yes	☐No
			Increased Sweating	☐ Yes	☐No	Sinus Pressure	☐ Yes	☐No
Constitutional			Fingernail Changes	☐ Yes	☐No			
Fatigue/Weakness	☐ Yes	☐No				**Eyes**		
Fever	☐ Yes	☐No				Double Vision	☐ Yes	☐No
Weight Gain/Loss	☐ Yes	☐No				Dry Eyes	☐ Yes	☐No
Jaw Pain when chewing	☐ Yes	☐No				Flashes/Floaters	☐ Yes	☐No
Scalp Tenderness	☐ Yes	☐No				Pain	☐ Yes	☐No

Explanations:____

____

____

_____________________________________ _____________________

Doctors Signature Review Date

Medical History Questionnaire

Name:_______________________________________Date:___ /____ /_______ Birth Date:___ / ___ / _______
Last Medical Exam: :___ /____ /______ Name of Medical Doctor:___________________Dr Phone:_________
Last Dental Exam: :___ /____ /_______ Name of Dentist: _________________________________

Past Oral/Medical History

HAVE YOU HAD OR DO YOU CURRENTLY HAVE

☐ Diabetes
☐Low Blood Sugar
☐ Damaged Heart Valves
☐ Mitral Valve Prolapse
☐ Stroke
☐ Chest pain/Angina
☐ Cardiac Pace Maker
☐ Heart Surgery
☐ Heart Attack
☐ Heart Murmur
☐Irregular Heart Beat
☐Osteoporosis/osteopenia
☐ Have you used Bisphosphonates or any Bone Density medications?
☐Eye disease/ glaucoma

☐Have you or a family member had unusual or serious reactions to anesthesia?

☐Mental Health problems/ anxiety/ depression, ADHD, OCD, Bipolar
☐Hepatitis, Jaundice or liver disease
☐Bleeding tendency/ abnormal bleeding
☐ Bronchitis
☐ Asthma
☐ Hay Fever/ Sinus
☐High Blood Pressure
☐Low Blood Pressure
☐Kidney Trouble?
☐Dialysis
☐Problems with immune system/Possibly from medication
☐Snoring

☐ Sleep Apnea
☐ Difficult breathing/other lung trouble
☐Epilepsy/ Seizures
☐A removable Dental appliance
☐Tuberculosis
☐Emphysema
☐Smoke
☐Chew Tobacco
☐Contagious Diseases
☐Sexually Transmitted Diseases
☐Delay in healing
☐A Tumor growth
☐Cancer/ radiation therapy/ chemotherapy
☐History of alcohol abuse
☐History of drug abuse
☐ History of prescription drug abuse
☐ History of preadolescent sexual abuse

Allergies: ☐None ☐Yes: (list)____
Please list any additional medical conditions: ____
____
List all major surgeries:____
____
List all prescription and over the counter medications you are currently taking: (Additional page available if needed)

Medication	Reason for taking	Dose	Amount/ Frequency

Are you pregnant or nursing? ☐No ☐Yes
Family History: (Check all that apply to your BLOOD relatives and then describe below)
☐Diabetes ☐Stroke ☐Dentures ☐Oral Cancer ☐Tooth Decay
☐Cancer ☐TB ☐Periodontitis ☐Tooth loss ☐ Heart Disease
☐Kidney Disease ☐Glaucoma ☐Osteoporosis ☐ Alcohol Abuse ☐ Drug Abuse
☐
Other:____

Condition:______________________ Relation:___________ Living☐ Deceased ☐ Approximate Age:_______
Condition:______________________ Relation:___________ Living☐ Deceased ☐ Approximate Age:_______

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO