Oral/Medical History

OFFICE USE ONLY	
	Acute cond.
	Allergy
	Blood dysc.
	Cardiac
	Diabetes
	Medication
	PN problem
	Pregnant
	Protection
	Resp. cond.
	Other cond.

Your answers to all these questions will aid your dentist in the proper treatment of your case. All information is confidential.
When a space is provided, please put an ⊗ in the circle to indicate your answer. Where lines are provided, please write in your answer.

1. Have you come to this office for the relief of pain? ○ yes ○ no
   If 'yes,' where is the pain? _____
   Have you had the pain more than three weeks? ○ yes ○ no
2. Have you been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ○ yes ○ no
3. Has a dentist or hygienist shown you how to clean your teeth? ○ yes ○ no
   If 'yes,' do you use this method of cleaning your teeth now? ○ yes ○ no
4. Do you have sores, swellings, or blisters on your gums, cheeks, or lips? ○ yes ○ no
   If 'yes,' have they been present longer than 3-4 weeks? ○ yes ○ no
5. Have you had orthodontic treatment to straighten your teeth? ○ yes ○ no
6. Please check any items below that you use often in mouth care
   ○ hand toothbrush ○ electric toothbrush
   ○ dental floss ○ gum stimulators, toothpicks, Stimudents
   ○ rubber tip ○ water spray
   ○ other
7. How would you describe your general health?
   ○ poor ○ fair ○ good
   Date of last medical examination? _____ month/year
8. Are you now being treated or have you been treated within the last year by a physician? ○ yes ○ no
9. Have you ever had an unusual reaction to dental anesthesia (gas or 'shots')? ○ yes ○ no
   If 'yes,' more than once? ○ yes ○ no
   Date of last occurrence? _____ month/year
10. Following injuries or dental treatment, have you had bleeding problems? ○ yes ○ no
    Have you ever taken diet med (phen-phen or redux) ○ yes ○ no
11. Is there a history of diabetes in your family? ○ yes ○ no
12. Are you thirsty most of the time? ○ yes ○ no
13. Have you recently lost weight unintentionally (with good appetite)? ○ yes ○ no
14. Do you urinate more than six times a day? ○ yes ○ no
15. Have you had eye trouble recently? ○ yes ○ no
16. Do injuries or cuts take longer to heal now than they did previously? ○ yes ○ no
17. Does your mouth feel dry or do you have a burning sensation of lips or tongue? ○ yes ○ no
18. Have you taken or been given injections of steroids such as cortisone? ○ yes ○ no

Make a checkmark against the following only if your answer is 'Yes.'

Have you become sick from, shown an allergy to, or been told not to take

19. ○ Antibiotics (penicillin, etc.)
20. ○ Codeine
21. ○ Novocaine or other dental anesthetics
22. ○ Other drugs or medicines or latex _____

Are you now taking or using medicines for

23. ○ Diabetes (pills or 'shots')
24. ○ Nerves (tranquilizers)
25. ○ Sleeping
26. ○ Heart or blood pressure (digitalis, nitroglycerin, reserpine)
27. ○ Blood (liver or iron pills, etc.)
28. ○ Stomach trouble (ulcer or other)
29. ○ Headaches
30. ○ Arthritis or rheumatism
31. ○ Allergy

Are you now
○ taking vitamins or herbs

32. ○ Artificial joints or veins
33. ○ On a prescribed diet
34. ○ Using thyroid
35. ○ Using hormones (including birth control pills)
36. ○ Using anticoagulents
37. ○ Using Dilantin
38. ○ Using other medicines or drugs (cocaine) _____

Have you ever had any of the following

39. ○ Heart disease, heart murmur, prolapse valve
40. ○ Shortness of breath without exercise or when lying down
41. ○ Swelling of ankles or feet
42. ○ Pain, pressure, or tight feeling in chest
43. ○ Heart attack
44. ○ Rheumatic fever
45. ○ High blood pressure
46. ○ Fainting spells, convulsions, epilepsy
47. ○ Frequent headaches (two or three a week)
48. ○ Headaches when lying down
49. ○ Nervous breakdown, psychotherapy
50. ○ Lung trouble (TB, asthma, emphysema)
51. ○ Hepatitis, liver disease, jaundice
52. ○ Arthritis, sore joints
53. ○ Diabetes
54. ○ Excessive bleeding
55. ○ Blood trouble, anemia, leukemia
56. ○ VD (syphilis, gonorrhea, HIV Positive (AIDS))
57. ○ X-ray, radium, or cobalt treatments
58. Is there any chance you are pregnant? ○ yes ○ no

Signature _____

Date _____

Physician's name _____

Physician's # _____