MEDICAL HISTORY

Have you been hospitalized in the past 5 years? Yes ___ No ___
Reason: ____

Have you had any major operations? Yes ___ No ___
Reason: ____

Are you under a physician's treatment ? Yes ___ No ___
Reason: ____

Physicians name ___________________________ Last seen ______

Have you had any of these conditions/characteristics past or present? Please check all that apply.

__ Acid Reflux
__ AID/HIV
__ Anorexia/Bulimia
__ Anxiety
__ Alcohol Addiction
__ Alzheimer's Disease
__ Artificial joint
__ Artificial heart valve
__ Arthritis/Gout
__ Atrial Fib (A-fib)
__ Autism
__ Blood Transfusion
__ Cancer
__ Cold Sores
__ Dementia
__ Depression
__ Diabetes/ Pre-Diabetes
__ Drug Addiction
__ Emphysema
__ Epilepsy or Seizures
__ Excessive Bleeding
__ Fainting/Dizziness
__ Heart Attack
__ Heart Failure
__ Heart Murmur
__ Heart Pacemaker
__ Hearing Aids
__ Hepatitis A
__ Hepatitis B or C
__ Herpes
__ High Blood Pressure
__ High Cholesterol
__ Leukemia
__ Lung Disease/ COPD
__ Mitral Valve Prolapse
__ Mouth Breather
__ Osteoporosis
__ Pain in Jaw Joint
__ Psychiatric Treatment
__ Radiation Treatment
__ Rheumatic Fever
__ Thyroid Disease
__ Sensory Issues
__ Stroke
__ Surgical Prosthesis
__ Ulcers
__ Venereal Disease

Have you ever had any other serious illness? Yes ___ No ___

If yes, please list.____

Please list any prescription medications you are currently taking and the reason for taking them. We do not need to know the dose.
If there are more that do not fit on this table, please provide a list to scan into our computer system.

Medication	Reason

Have you ever taken any medications containing bisphosphonates; Redux, Fosamax, Boniva, Actonel? Yes ___ No ___ If yes, please list.

Women

Are you pregnant? Yes ___ No ___ Trying to get pregnant? Yes ___ No ___
Taking oral contraceptives? Yes ___ No ___ Breastfeeding? Yes ___ No ___

Allergies:

Do you have any allergies to medications? Please list them

____

Do you have a LATEX allergy? Yes ___ No ___
Do you have a sensitivity to epinephrine in local anesthesia? Yes ___ No ___

Do you smoke or use tobacco products? Yes ___ No ___
If you, how much___________ and for how long___________

DENTAL

Thank you for choosing our office.
What can we do for you at this time?___________________________________

Are you comfortable during dental visits? Yes ___ No ___
If not, what can we do for you to make you more comfortable?
____

Has fear of discomfort kept you from regular visits? Yes ___ No ___

When was your last dental visit? ___________ Purpose:___________________

*if you had x-rays taken at a previous office within the past few years, it is always helpful to have that office email a copy to us
at **mgr@sirockydds.com** *

Would you like routine dental care? Every **3** **4** **6** months

Do you have food traps? Yes ___ No ___ Does floss get stuck Yes ___ No ___
Have you had braces? Yes ___ No ___ Do your gums bleed Yes ___ No ___

Do you prefer local anesthesia when necessary? Yes ___ No ___

Do you have a bad taste in your mouth at times? Yes ___ No ___

Do you have pain clicking or popping in your jaw joint? Yes ___ No ___

Have you ever been diagnosed with gum disease? Yes ___ No ___

Are there any questions you would like answered?

____

I understand the importance of a truthful and complete health history to assist the doctors/staff in providing the best possible care. I have read and understand the above information

PATIENT SIGNATURE(OR PARENT/GUARDIAN IF MINOR)_________________________________

DATE ___________________

Please print this form and bring it to your appointment.