

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

<input type="checkbox"/> Diabetes <input type="checkbox"/> Low Blood Sugar <input type="checkbox"/> Damaged Heart Valves <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Stroke <input type="checkbox"/> Chest pain/Angina <input type="checkbox"/> Cardiac Pace Maker <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Osteoporosis/osteopenia <input type="checkbox"/> Have you used Bisphosphonates or any Bone Density medications? <input type="checkbox"/> Eye disease/ glaucoma <input type="checkbox"/> Have you or a family member had unusual or serious reactions to anesthesia?	<input type="checkbox"/> Mental Health problems/ anxiety/ depression, ADHD, OCD, Bipolar <input type="checkbox"/> Hepatitis, Jaundice or liver disease <input type="checkbox"/> Bleeding tendency/ abnormal bleeding <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Hay Fever/ Sinus <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Kidney Trouble? <input type="checkbox"/> Dialysis <input type="checkbox"/> Problems with immune system/Possibly from medication <input type="checkbox"/> Snoring	<input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Difficult breathing/other lung trouble <input type="checkbox"/> Epilepsy/ Seizures <input type="checkbox"/> A removable Dental appliance <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Smoke <input type="checkbox"/> Chew Tobacco <input type="checkbox"/> Contagious Diseases <input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Delay in healing <input type="checkbox"/> A Tumor growth <input type="checkbox"/> Cancer/ radiation therapy/ chemotherapy <input type="checkbox"/> History of alcohol abuse <input type="checkbox"/> History of drug abuse <input type="checkbox"/> History of prescription drug abuse <input type="checkbox"/> History of preadolescent sexual abuse
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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: _____

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PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO