

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/Floaters	<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: _____
 Condition: _____ Relation: _____ Living ☐ Deceased ☐ Approximate Age: _____

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO