PATRIOTS PARK DENTAL

MEDICAL HISTORY/HEALTH QUESTIONAIRE

Patient Name:____**Date of Birth**__________________________

Family Doctor:____**Address:**_____________________________

Reason for today's visit:____

To your knowledge do you now have or have you ever had any of the following:

RESPIRATORY PROBLEMS	**YES**	**NO**	**NEUROLOGICAL PROBLEMS**	**YES**	**NO**
Asthma			Stroke/TIA/Mini-stroke		
Tuberculosis			Multiple sclerosis		
Sleep apnea			Epilepsy/Seizure disorder		
Bronchitis/Emphysema			Neuropathy/Neuropathic pain		
HEMATOLOGIC PROBLEMS	**YES**	**NO**	**ENDOCRINE PROBLEMS**	**YES**	**NO**
Anemia			Diabetes		
Sickle cell disease/trait			Thyroid disorder		
HIV disease/AIDS			**Cancer**	**YES**	**NO**
Bleeding disorders			Radiation treatment		
Coumadin/warfarin treatment			Chemotherapy treatment		
CARDIOVASCULAR PROBLEMS	**YES**	**NO**	**Other Problems**	**YES**	**NO**
High blood pressure/Hypertension			Renal/Kidney disease		
Angina/Chest pain			Fibromyalgia		
Heart attack/Myocardial infarction			Arthritis		
Prosthetic (artificial) heart valve			Used a bisphosphonate medication for osteoporosis or cancer treatment		
Congestive heart failure			Psychiatric treatment		
Heart bypass or stent surgery			Pregnant		
Gastrointestinal Problems	**YES**	**NO**	Breast feeding		
Hepatitis/Jaundice			Dry mouth/Sjogren's Syndrome		
Liver disease			Mouth ulcers/sores		
Gerd/Reflux/Ulcers			TMJ/Temporomandibular disorders		
Joint Replacement: Please explain if yes and provide dates					
Eye Surgery: Please explain if yes					

SOCIAL HISTORY	**YES**	**NO**	
Tobacco/ Vaping			Number of years?________
Alcoholic Beverages			How much per week?_______
Recreational drugs			What and how often?_______

PREVIOUS HOSPITALIZATIONS	**YES**	**NO**	
Have you ever been hospitalized?			**Reason?**__________________________ __________________________________

Please List

MEDICATIONS	ALLERGIES

Unusual Reaction to dental injections?____

New Patients:

Have you had a Panoramic x-ray or Full Mouth x-rays in the past 5 years?___________________________

Have you had a Bitewing x-ray in the past year?____

Name of former dentist_______________________________**City/State**____________________________

Date of last cleaning and exam____

Pain assessment:

	YES	NO	Where
Are you having a problem with pain?			

If yes, please circle your level of pain, with 10 being the worst:

1 2 3 4 5 6 7 8 9 10

PATIENT SIGNATURE:

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes, I will inform my doctor at my next appointment.

Signature of Patient:____

Signature of Parent/Guardian:_______________________________ **Date:**______________

DOCTOR SIGNATURE:

I have reviewed the patient's medical history.

Signature of Doctor:____ **Date:**______________

N/V____