

HEAVENLY SMILES DENTAL Patient Medical History

PATIENT NAME: _____ **DATE:** _____

Are you under a physician's care now? ___Y___N If yes, why? _____

Do you have any chief complaint or concerns? ___Y___N If Yes, what? _____

In what relative time frame do you want your concern to be addressed? ___ **NOW!** ___ 1 Week ___ 1 Month ___ 1 Year

Are you happy with your smile? ___Y___N If no, explain why: _____

Would you like to have your teeth whitened? ___Y___N

Would you want to replace any old crowns that do not match your other teeth or have dark lines at the gum? ___Y___N

Would you like to change your black or silver fillings to white ones? ___Y___N

Would you like to replace any old or stained fillings that show when you smile? ___Y___N

Do you have any gaps, or missing teeth you would like to replace to improve your smile and bite? ___Y___N

Would you like to straighten your teeth or tooth, to correct any crowding, spacing or an uneven bite? ___Y___N

Do you snore? ___Y___N If yes, on what level? ___Minimal ___Moderate ___Severe

Do you have sleep apnea? ___Y___N If yes, what level? ___Minimal ___Moderate ___Severe

Do you feel tired after waking up, or feel like taking naps during the day? ___ **DEFINITELY!** ___Y___N

WOMEN: Are you pregnant/ trying to get pregnant? ___Y___N	If yes, how many weeks? _____
Are you taking oral contraceptives? ___Y___N	Nursing? ___Y___N

Are you allergic to any of the following:

___Aspirin___Penicillin___Codeine___Acrylic___Metal___Local Anesthetics___Other, please list: _____

Are you taking any medications, pills or drugs? ___Y___N Please List: _____

Do you have, or have had any of the following:

<input type="checkbox"/> Change in Bite	<input type="checkbox"/> Angina	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Clenching/Grinding	<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Dizziness/Loss of Balance	<input type="checkbox"/> Artificial Joints/Heart Valves	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Earaches/Ringing in Ears	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Rheumatic Fever*
<input type="checkbox"/> Ear stuffiness/Loss of Hearing	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Shingles
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Jaw Clicking/Popping	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Hepatitis A/B or C	<input type="checkbox"/> Spinal Bifida
<input type="checkbox"/> Jaw Locking/Catching	<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Stomach Disease
<input type="checkbox"/> Jaw Pain/Tired Jaw Muscles	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes I or II	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Venereal Disease
	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Yellow Jaundice
	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tobacco Use
	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Mitral Valve Prolapse*	
		<input type="checkbox"/> Prolonged Bleeding	

Have you ever had any serious illness not listed above? ___Y___N If yes, please explain: _____