PENINSULA
DENTAL CARE

Today's Date:__/__/____

# *MEDICAL AND DENTAL HISTORY*

Name_____ Birthday__/__/____

1. Are you in good health? YES NO
2. Has there been any change in you general health within the past year? YES NO
3. Date of last physical examination_____
4. Are you now under the care of a physician or health care professional? YES NO
If so, what is the condition being treated?_____
5. Name and address of physician _____
Phone number_____
6. Have you had any serious illnesses, operation, or been hospitalized in the past five years? YES NO
If so, what was the problem? YES NO
7. **FEMALES ONLY:** Are you pregnant? YES NO
Do you take oral contraceptives? YES NO

**8. DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?(circle all that apply)**

**SKIN**
* Itching YES NO
* Rash/Hives YES NO
* Ulcers YES NO
* Pigmentation or skin color change YES NO
* Lack or loss of body hair YES NO
* Other_____

**EYES / EARS / NOSE / THROAT**
* Visual change/blurring YES NO
* Glaucoma YES NO
* Loss of hearing YES NO
* Ringing in ears YES NO
* Frequent ear infection YES NO
* Frequent nose bleeds YES NO
* Sinus Problems YES NO
* Other_____

**RESPIRATORY (LUNGS)**
* Tuberculosis YES NO
* Emphysema/bronchitis YES NO
* Asthma/wheezing YES NO
* Persistent cough YES NO
* Other_____

**DIGESTIVE SYSTEM**
* Hepatitis YES NO
* Jaundice YES NO
* Liver Disease YES NO
* Ulcers YES NO
* Change in appetite YES NO
* Black or bloody stools YES NO
* Other_____

**BONE / MUSCLES**
* Bone Deformity/fracture YES NO
* Arthritis/rheumatic YES NO
* Artificial joint YES NO
* Muscle weaknesses/pain YES NO
* Other_____

**HEART / BLOOD VESSELS**
* Rheumatic fever YES NO
* Heart Murmur YES NO
* Chest Pain YES NO
* Heart attack YES NO
* Shortness of breath YES NO
* Swelling of ankles YES NO
* High/Low blood pressure YES NO
* Congenital heart disease YES NO
* Prosthetic valves YES NO
* Heart Surgery YES NO
* Pacemaker YES NO
* Other_____

**GENITOURINARY**
* Kidney Disease YES NO
* Kidney transplant/dialysis YES NO
* Difficulty/pain on urination YES NO
* Blood in urine YES NO
* Frequent Urination YES NO
* Sexually transmitted disease YES NO
* Syphilis YES NO
* Gonorrhea YES NO
* Herpes YES NO
* Other_____

**PSYCHIATRIC**
* Nervousness YES NO
* Irritability YES NO
* Depression/excessive worry YES NO
* Nervous breakdown YES NO
* Other_____

**GENERAL**
* Tire easily YES NO
* Weakness YES NO
* Night Sweats YES NO
* Persistent fever YES NO
* Other_____

**BLOOD / LYMPH / IMMUNE**
* Easy bruising/excessive bleeding YES NO
* Persistent swollen glands YES NO
* Blood transfusion YES NO
* Hemophilia YES NO
* Anemia/sickle cell YES NO
* HIV positive YES NO
* AIDS YES NO
* Leukemia YES NO
* Spleen problems YES NO
* Other_____

**NERVOUS SYSTEM**
* Frequent headaches YES NO
* Dizziness/fainting YES NO
* Epilepsy / seizures / convulsions YES NO
* Neuritis/neuralgia YES NO
* Parasthesias / numbness / tingling YES NO
* Paralysis YES NO
* Hydrocephalic shunt YES NO
* Other_____

**ENDOCRINE (GLANDS)**
* Diabetes YES NO
* Thyroid trouble/goiter YES NO
* Weight Change YES NO
* Excessive thirst YES NO
* Other_____

**OTHER**
* Radiation therapy YES NO
* Chemotherapy YES NO
* Tumors or growth YES NO
* Cancer YES NO
* Alcohol use YES NO
* Tobacco use YES NO
* Other_____

**12. Do you have or have you ever had any of the following (circle all that apply)**

*Facial Pain YES NO
Joint Sounds-popping/clicking YES NO
*Limited Jaw Motion YES NO
*Muscle Spasms YES NO
*Headaches YES NO
*Jaw Locking YES NO

*Have you had Botox or/and Lip Fillers* YES NO *If yes, Date*