

Yes 🗀 No 🗀

seizure disorder, epilepsy, convulsion

Accurate answers will help us provide you the safest treatment experience. All information you provide is confidential.

If you need assistance or have a question, please ask.

PATIENT MEDICAL HISTORY  Date of Birth	Patient's	Name						
Date of Birth			Last	First			Middle	Today's Date
Your PHYSICIAN'S name and phone #  Yes   No   Have you ever been hospitalized or had surgery?  If yes, please give year and reasons or types of operations.  Yes   No   Latex sensitivity  Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.  MEDICATIONS  Have you ever taken any of the following:  Yes   No   severe headaches, migraines fainting, dizziness  eating disorder, anorexia, bulimia depression, psychosis, schizophrenia anticoagulants  Yes   No   heparin, coumadin, blood thinners, anticoagulants  Yes   No   antidepressants, sedatives, psychiatric deficine  Yes   No   heart or blood pressure medications  Yes   No   heart or blood pressure medications  Yes   No   nitroglycerin  Yes   No   nitroglycerin  Yes   No   heparin, phen, pondimen, Redux  Yes   No   hepatitis, cirrhosis, liver disease  currently taking			PATIENT MEDICAL HISTOR	Υ				
Your PHYSICIAN'S name and phone #  Yes   No   Have you ever been hospitalized or had surgery?  If yes, please give year and reasons or types of operations.  Yes   No   Latex sensitivity  Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.  MEDICATIONS  Have you ever taken any of the following:  Yes   No   severe headaches, migraines fainting, dizziness  eating disorder, anorexia, bulimia depression, psychosis, schizophrenia anticoagulants  Yes   No   heparin, coumadin, blood thinners, anticoagulants  Yes   No   antidepressants, sedatives, psychiatric deficine  Yes   No   heart or blood pressure medications  Yes   No   heart or blood pressure medications  Yes   No   nitroglycerin  Yes   No   nitroglycerin  Yes   No   heparin, phen, pondimen, Redux  Yes   No   hepatitis, cirrhosis, liver disease  currently taking	Date of E	Birth	/ / Date of last physica	l exam /	/			
Have you ever been hospitalized or had surgery?   If yes, please give year and reasons or types of operations.								
If yes, please give year and reasons or types of operations.								
Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.  MEDICATIONS  MEDICATIONS  Have you ever taken any of the following:  Yes   No   cortisone, steroids  Yes   No   depression, psychosis, schizophrenia anticoagulants  Yes   No   antidepressants, sedatives, psychiatric medicine  Yes   No   heard to blood pressure medications  Yes   No   heard to blood pressure medications  Yes   No   introglycerin  Yes   No   ren-Phen, Pondimen, Redux  Yes   No   sexure headaches, migraines  fainting, dizziness  Yes   No   psychiatric care, counseling  neurological or neuromuscular disorder  ulcer or stomach problem  Yes   No   chronic diarrhea, intestinal problem  Yes   No   stidney or bladder problem  Yes   No   sexually transmitted disease  Head to renew the sexually transmitted disease  Yes   No   sexually transmitted disease  Yes   No   diabetes or high blood sugar  Yes   No   diabetes or high blood sugar  Yes   No   diabetes or high blood sugar  Yes   No   weight change greater than 10 pounds in  the last year?  Yes   No   do you exercise regularly  Yes   No   do you exercise regularly  Yes   No   mitral valve prolapse, heart murmur  Yes   No   mitral valve prolapse, heart murmur  Yes   No   cortisone, steroids  Yes   No   diabetes or high blood disorder, blood disorder, blood transfusion, sickle cell artificial joints  Yes   No   do you exercise regularly  Yes   No   do you exercise regularly  Yes   No   arthritis, joint pain, back problems  Yes   No   angina, chest pain  Yes   No   arthritis, joint pain, back problems  Skin problem or disease  Yes   No   arthritis, joint pain, back problems  Skin problem or disease	Yes 🖵	No 🗀	Have you ever been hospitalized or had su	irgery?				
Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.  MEDICATIONS  Yes			If yes, please give year and reasons or type	oes of operations				
MEDICATIONS    No	Yes 🖵	No 🖵	Latex sensitivity					
Have you ever taken any of the following:  Yes   No   cortisone, steroids  Yes   No   heparin, coumadin, blood thinners, anticoagulants  Yes   No   heparin, coumadin, blood thinners, anticoagulants  Yes   No   psychiatric care, counseling  Yes   No   neurological or neuromuscular disorder psychiatric medicine  Yes   No   heart or blood pressure medications  Yes   No   chronic diarrhea, intestinal problem  Yes   No   sexually transmitted disease  Yes   No   sexually transmitted disease  Yes   No   hepatitis, cirrhosis, liver disease  Yes   No   diabetes or high blood sugar  Yes   No   diabetes or high blood sugar  Yes   No   weight change greater than 10 pounds in the last year  Yes   No   bleeding problem, hemophilia the last year  Yes   No   diabetes or high blood sugar  Yes   No   bleeding problem, hemophilia the last year  Yes   No   diabetes or high blood sugar  Yes   No   do you exercise regularly  Yes   No   do you exercise regularly  Yes   No   mitral valve prolapse, heart murmur  Yes   No   arificial joints  Arthritis, joint pain, back problems  Yes   No   arificial problem or disease  Yes   No   skin problem or disease  Yes   No   cancer or tumor  Yes   No   skin problem or disease  Yes   No   cancer or tumor  Yes   No   radiation treatment, chemotherapy	Please	e mark	YES or NO and CIRCLE any spe	ecific condition	n you cu	ırrently	y have or have had p	reviously.
Have you ever taken any of the following:  Yes   No   cortisone, steroids  Yes   No   heparin, coumadin, blood thinners, anticoagulants  Yes   No   heparin, coumadin, blood thinners, anticoagulants  Yes   No   psychiatric care, counseling  Yes   No   neurological or neuromuscular disorder psychiatric medicine  Yes   No   heart or blood pressure medications  Yes   No   chronic diarrhea, intestinal problem  Yes   No   sexually transmitted disease  Yes   No   sexually transmitted disease  Yes   No   hepatitis, cirrhosis, liver disease  Yes   No   diabetes or high blood sugar  Yes   No   diabetes or high blood sugar  Yes   No   weight change greater than 10 pounds in the last year  Yes   No   bleeding problem, hemophilia the last year  Yes   No   diabetes or high blood sugar  Yes   No   bleeding problem, hemophilia the last year  Yes   No   diabetes or high blood sugar  Yes   No   do you exercise regularly  Yes   No   do you exercise regularly  Yes   No   mitral valve prolapse, heart murmur  Yes   No   arificial joints  Arthritis, joint pain, back problems  Yes   No   arificial problem or disease  Yes   No   skin problem or disease  Yes   No   cancer or tumor  Yes   No   skin problem or disease  Yes   No   cancer or tumor  Yes   No   radiation treatment, chemotherapy	MEDIC	ATIONS			Yes 🖵	No □	severe headaches, migraine	S
Yes   No   cortisone, steroids   Yes   No   eating disorder, anorexia, bulimia   Yes   No   heparin, coumadin, blood thinners, anticoagulants   Yes   No   psychiatric care, counseling   psychiatric medicine   Yes   No   ulcer or stomach problem   ves   No   ulcer or stomach problem   ves   No   thronic diarrhea, intestinal problem   ves   No   sexually transmitted disease   ves   No   sexually transmitted disease   ves   No   theart or blood pressure medications   ves   No   sexually transmitted disease   ves   No   sexually transmitted disease   ves   No   theart or blood pressure medications   ves   No   sexually transmitted disease   ves   No   theart stack, heart disease   ves   No   theart stack, heart disease   ves   No   the patitis, cirrhosis, liver disease   ves   No   the patitis, cirrhosis, the patitis, cirrhosis, liver disease   ves   No   the patit			en any of the following:					-
Yes       No       depression, psychosis, schizophrenia anticoagulants         Yes       No       psychiatric care, counseling antidepressants, sedatives, psychiatric medicine       Yes       No       psychiatric care, counseling neurological or neuromuscular disorder neuromuscular disorder psychiatric medicine       Yes       No       neurological or neuromuscular disorder neuromuscular disorder neuromuscular disorder neuromuscular disorder neuromuscular disorder yes         Yes       No       heart or blood pressure medications       Yes       No       chronic diarrhea, intestinal problem         Yes       No       nitroglycerin       Yes       No       kidney or bladder problem         Yes       No       psychiatric care, counseling       neurological or neuromuscular disorder         Yes       No       chronic diarrhea, intestinal problem         Yes       No       kidney or bladder problem         Yes       No       kidney or bladder problem         Yes       No       sexually transmitted disease         Please list all prescription and over-the-counter medications you are       Yes       No       hepatitis, cirrhosis, fiver disease         currently taking       Fen-Phen, Pondimen, Redux       Yes       No       hepatitis, cirrhosis, fiver disease         ves       No       desperbolems or infection       yes       No								ulimia
anticoagulants  Yes   No   psychiatric care, counseling  No   neurological or neuromuscular disorder  yes   No   diabert or blood pressure medications  Yes   No   chronic diarrhea, intestinal problem  yes   No   sexually transmitted disease  Please list all prescription and over-the-counter medications you are  currently taking   Yes   No   hepatitis, cirrhosis, liver disease  yes   No   sinus problems or disease  yes   No   diabetes or high blood sugar  yes   No   diabetes or high blood sugar  yes   No   diabetes or high blood sugar  yes   No   been tested for HIV  in the last year?   Yes   No   bleeding problem, hemophilia  the last year   Yes   No   bleeding problem, hemophilia  the last year   Yes   No   blood disorder, blood transfusion, sickle cell  artificial joints  Yes   No   orgenital heart defects, artificial valves, endocarditis  Yes   No   arthritis, joint pain, back problems  Yes   No   heart attack, heart disease   Yes   No   cancer or tumor  Yes   No   heart attack, heart disease   Yes   No   cancer or tumor  Yes   No   pacemaker, irregular heart beat   Yes   No   cancer or tumor  Yes   No   ardiation treatment, chemotherapy			•		Yes 🖵			
Yes       No       neurological or neuromuscular disorder         Yes       No       neurological or neuromuscular disorder         Yes       No       ulcer or stomach problem         Yes       No       chronic diarrhea, intestinal problem         Yes       No       kidney or bladder problem         Yes       No       kidney or bladder problem         Yes       No       sexually transmitted disease         Please list all prescription and over-the-counter medications you are       Yes       No       hepatitis, cirrhosis, liver disease         currently taking       Yes       No       hepatitis, cirrhosis, liver disease         Yes       No       hepatitis, cirrhosis, liver disease         Yes       No       hepatitis, cirrhosis, liver disease         Yes       No       eye problems or infection         Yes       No       ear problems or infection         Yes       No       swolleng glands or lymph nodes         Yes       No       been tested for HIV         Yes       No       helades year         Yes       No       bleeding problem, hemophilia         Yes       No       bruise easily, slow healing         Yes       No       blood disorder, blood transfusion, sickle cel					Yes 🖵	No 🖵		•
psychiatric medicine  Yes   No   ulcer or stomach problem  Yes   No   chronic diarrhea, intestinal problem  Yes   No   chronic diarrhea, intestinal problem  Yes   No   chronic diarrhea, intestinal problem  Yes   No   kidney or bladder problem  Yes   No   sexually transmitted disease  Yes   No   hepatitis, cirrhosis, liver disease  Yes   No   eye problems or disease  Yes   No   sinus problems or infection  Yes   No   diabetes or high blood sugar  Yes   No   swollen glands or lymph nodes  Yes   No   been tested for HIV  In the last year?  Yes   No   bleeding problem, hemophilia  The last year  Yes   No   blood disorder, blood transfusion, sickle cell  Yes   No   blood disorder, blood transfusion, sickle cell  Yes   No   artificial joints  Yes   No   angina, chest pain  Yes   No   skin problem or disease  Yes   No   cancer or tumor  Yes   No   radiation treatment, chemotherapy	Yes 🖵	No 🖵	-		Yes 🖵	No 🖵		lar disorder
Yes   No   heart or blood pressure medications Yes   No   chronic diarrhea, intestinal problem Yes   No   kidney or bladder problem Yes   No   kidney or bladder problem Yes   No   sexually transmitted disease Yes   No   hepatitis, cirrhosis, liver disease Yes   No   hepatitis, cirrhosis, liver disease Yes   No   hepatitis, cirrhosis, liver disease Yes   No   eye problems or infection Yes   No   diabetes or high blood sugar Yes   No   diabetes or high blood sugar Yes   No   diabetes or high blood sugar Yes   No   been tested for HIV Yes   No   been tested for HIV Yes   No   bleeding problem, hemophilia Yes   No   blood disorder, blood transfusion, sickle cell Yes   No   diabetes or high blood for lymph nodes Yes   No   blood disorder, blood transfusion, sickle cell Yes   No   blood disorder, blood transfusion, sickle cell Yes   No   arthritis, joint pain, back problems Yes   No   skin problem or disease Yes   No   cancer or tumor Yes   No   pacemaker, irregular heart beat Yes   No   radiation treatment, chemotherapy					Yes 🖵	No 🖵		
Yes   No   nitroglycerin   Yes   No   kidney or bladder problem   Yes   No   sexually transmitted disease   No   sexually transmitted disease   Yes   No   hepatitis, cirrhosis, liver disease   Yes   No   hepatitis, cirrhosis, liver disease   Yes   No   hepatitis, cirrhosis, liver disease   Yes   No   eye problems or disease   Yes   No   ear problems or infection   Yes   No   diabetes or high blood sugar   Yes   No   diabetes or high blood sugar   Yes   No   been tested for HIV   No   hepatitis, cirrhosis, liver disease   Yes   No   eye problems or disease   Yes   No   diabetes or high blood sugar   Yes   No   diabetes or high blood sugar   Yes   No   been tested for HIV   No   hepatitis, cirrhosis, liver disease   Yes   No   exproblems or infection   Yes   No   diabetes or high blood sugar   Yes   No   been tested for HIV   No   been tested for HIV   Yes   No   been tested for HIV   Yes   No   bleeding problem, hemophilia   Hillow   HIV+, ARC, AIDS   HIV+, ARC, AIDS   helding problem, hemophilia   Yes   No   blood disorder, blood transfusion, sickle cell   Yes   No   artificial joints   Artificial joints   Yes   No   artificial joints   Artificial joints   Yes   No   arthritis, joint pain, back problems   Yes   No   skin problem or disease   Yes   No   skin problem or disease   Yes   No   cancer or tumor   Yes   No   radiation treatment, chemotherapy	Yes 🖵	No 🖵			Yes 🖵	No 🖵		oroblem
Yes   No   Fen-Phen, Pondimen, Redux   Yes   No   sexually transmitted disease   Please list all prescription and over-the-counter medications you are   Currently taking   Yes   No   hepatitis, cirrhosis, liver disease   Yes   No   eye problems or disease   Yes   No   sinus problems or infection   Yes   No   diabetes or high blood sugar   Yes   No   diabetes or high blood sugar   Yes   No   swollen glands or lymph nodes   Yes   No   been tested for HIV   No   been tested for HIV   HIV+, ARC, AIDS   HIV+, ARC, A		No 🖵			Yes 🖵	No 🖵		
Please list all prescription and over-the-counter medications you are  currently taking	Yes 🖵	No 🖵			Yes 🖵	No 🖵	sexually transmitted disease	<u>)</u>
currently taking		st all pres		ı are	Yes 🖵	No 🖵	hepatitis, cirrhosis, liver dise	ease
Yes   No   sinus problems or infection Yes   No   ear problems or infection Yes   No   diabetes or high blood sugar Yes   No   swollen glands or lymph nodes Yes   No   been tested for HIV Yes   No   HIV+, ARC, AIDS Yes   No   bleeding problem, hemophilia The last year Yes   No   bleeding problem, hemophilia The last year Yes   No   blood disorder, blood transfusion, sickle cell Yes   No   mitral valve prolapse, heart murmur Yes   No   artificial joints Yes   No   arthritis, joint pain, back problems Yes   No   heart attack, heart disease Yes   No   pacemaker, irregular heart beat Yes   No   radiation treatment, chemotherapy		-			Yes 🖵	No 🖵	eye problems or disease	
Yes   No   diabetes or high blood sugar Yes   No   diabetes or high blood sugar Yes   No   swollen glands or lymph nodes Yes   No   been tested for HIV In the last year? Yes   No   HIV+, ARC, AIDS Yes   No   bleeding problem, hemophilia the last year Yes   No   bleeding problem, hemophilia the last year Yes   No   blood disorder, blood transfusion, sickle cell Yes   No   artificial joints Yes   No   artificial joints Yes   No   arthritis, joint pain, back problems Yes   No   heart attack, heart disease Yes   No   pacemaker, irregular heart beat Yes   No   radiation treatment, chemotherapy	carrentin				Yes 🖵	No 🖵	sinus problems or infection	
Yes   No   Any change in your general health in the last year?  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Weight change greater than 10 pounds in the last year  Yes   No   Wes   No   Wes   Wes   No   Wes					Yes 🖵	No 🖵	ear problems or infection	
Yes       No       Any change in your general health in the last year?       Yes       No       been tested for HIV         Yes       No       HIV+, ARC, AIDS         Yes       No       bleeding problem, hemophilia         Yes       No       bleeding problem, hemophilia         Yes       No       blood disorder, blood transfusion, sickle cell         Yes       No       artificial joints         Yes       No       arthritis, joint pain, back problems         Yes       No       arthritis, joint pain, back problems         Yes       No       skin problem or disease         Yes       No       cancer or tumor         Yes       No       radiation treatment, chemotherapy					Yes 🖵	No 🖵	diabetes or high blood sugar	
in the last year?  Yes \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \					Yes 🖵	No 🖵	swollen glands or lymph nod	es
Yes  No bleeding problem, hemophilia the last year Yes  No bleeding problem, hemophilia the last year Yes  No bleeding problem, hemophilia The last year Yes  No blood disorder, blood transfusion, sickle cell Yes  No artificial joints Yes  No artificial joints Yes  No artificial yalves, endocarditis Yes  No arthritis, joint pain, back problems Yes  No angina, chest pain Yes  No artificial yalves, endocarditis Yes  No arthritis, joint pain, back problems Yes  No heart attack, heart disease Yes  No pacemaker, irregular heart beat Yes  No radiation treatment, chemotherapy	Yes 🖵	No 🖵			Yes 🖵	No 🖵	been tested for HIV	
the last year  Yes No bruise easily, slow healing  Yes No blood disorder, blood transfusion, sickle cell  Yes No artificial joints  Yes No artificial joints  Yes No arthritis, joint pain, back problems  Yes No angina, chest pain  Yes No beart attack, heart disease  Yes No pacemaker, irregular heart beat  Yes No radiation treatment, chemotherapy	–	=	•		Yes 🖵	No 🖵		
Yes \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Yes 🖵	No 🖵			Yes 🖵	No 🖵		a
Yes \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	v 🗔	N 🗀	•					
Yes \( \) No \( \) congenital heart defects, artificial valves, endocarditis Yes \( \) No \( \) arthritis, joint pain, back problems Yes \( \) No \( \) skin problem or disease Yes \( \) No \( \) heart attack, heart disease Yes \( \) No \( \) pacemaker, irregular heart beat  Yes \( \) No \( \) radiation treatment, chemotherapy								usion, sickle cell
Yes \( \bigcap \text{No} \( \bigcap \) angina, chest pain \\ Yes \( \bigcap \text{No} \( \bigcap \) keart attack, heart disease \\ Yes \( \bigcap \text{No} \( \bigcap \) pacemaker, irregular heart beat \\ Yes \( \bigcap \text{No} \( \bigcap \) radiation treatment, chemotherapy			,	.do.oo.uditio			•	
Yes \( \buildred{\text{No}} \) heart attack, heart disease \( \text{Yes} \) No \( \buildred{\text{No}} \) cancer or tumor \( \text{Yes} \) No \( \buildred{\text{No}} \) radiation treatment, chemotherapy				uocarditis				blems
Yes \( \bullet \ No \( \bullet \) pacemaker, irregular heart beat \( Yes \( \bullet \) No \( \bullet \) radiation treatment, chemotherapy								
Too 2 To 2 Tourish a common of the common of								
TES - INVIA HEALT SULYELY YAS IN NO - NAST OF PRESENT ARIJO HIS INCHINING COCAINA			, , ,					
pust of present and ascenticating execution,			<u> </u>		Yes 🖵	No 🖵		
or doing methalining etci.					V- 🗀	N - 🗀	crack, methamphetamine, etc.	
V. S. N. S					yes 🖵	ио 🗖	do you smoke? # of packs per day	
<u></u>				nnea	Va - 🖵	Na □	for how long?	
The second secon				prica			chewing tobacco or snuff	
					yes 🖵	ио 🗀	do you drink alcohol?	
					Voc 🗀	No □	# of drinks per week	
Yes  No  o do you participate in any sports					res 🖵	INO 🗀	uo you participate iii ally SpC	ກ ເວ

ALLER	GIES		WOMEN ONLY				
Do you h	nave any o	of the following allergies:	Yes 📮 No 🗀 are you pregnant or possibly pregnant				
Yes 🖵	No 🖵	Penicillin, sulfa, any antibiotic	Yes 🗖 No 🗖 are you nursing				
Yes 🖵	No 🖵	local anesthetics (novocaine, lidocaine, etc.)	Yes 🔲 No 🗀 are you taking birth control pills				
Yes 🖵	No 🖵	aspirin, codeine, or other pain medication					
Yes 🖵	No 🖵	hives, contact dermatitis, latex sensitivity					
Yes 🖵	No 🗖	allergic to any other medication	_				
Yes 🖵	No 🗖	Do you have any disease, condition or problem not listed above?					
	L HISTO		Yes  No  any complication with / reaction to past				
Yes 🖵		tooth or mouth pain recently	dental treatment				
Yes 🖵	No 🖵	how nervous does dental treatment make you:	Yes 🗖 No 🗖 any injury to your teeth, mouth, jaws, or head				
		not at all slightly	December today's visit				
Yes □	No 🖵	moderately extremely any awareness of clenching or grinding your teeth	Reason for today's visit				
Yes 🖵	No 🗖	jaw clicking, popping, or grinding	How do you feel about the appearance of your front teeth				
Yes 🖵	No 🖵	jaw or TMJ pain	non do you real about the appearance or your none teeth				
Yes 🖵	No 🖵	ever worn partials or dentures					
Yes 🖵	No 🗖	orthodontic treatment / braces	Yes No do you have any other dental concerns				
Yes 🖵	No 🖵	ulcers / sores in mouth or on lips					
Yes 🖵	No 🖵	unpleasant taste / bad breath	Previous dentists name				
Yes 🖵	No 🖵	swelling, lumps, bumps in mouth	City				
Yes 🖵	No 🖵	periodontal / gum surgery or disease	Date of last dental treatment				
Yes 🖵	No 🖵	oral surgery					
Yes 🖵	No 🖵	any unpleasant experience with dental					
		treatment. If yes, describe	_				
		an be very dangerous to my health. I also unde	have been accurately answered. I understand that providing incorrect erstand it is very important to report any changes in my medical or denta he earliest time, and I agree to do so.				
Signatur	re		Date Relationship to patient if other than self				
doing.	I consei ographic	of Dr I undersont to my dentist, or a representative of his staff	IMAGE AND BIOGRAPHICAL INFORMATION tand that my dentist may take video or still images of the work that he is taking these images. I understand that my dentist may use my images, purposes of education, publicity, promotion and advertising. I understand				
Signatur	re		 Date				