

"TMD and Restorative Dentistry"

Date _____

_____ Birthdate _____ Age _____ Soc. Sec. No. _____

Last Name First Name Initial

Home Address _____ Home Ph. No. _____

City _____ State _____ Zip _____ Business Ph.No. _____

Occupation _____ Employer _____ e-Mail _____

Spouse Name _____

Medical History

Physician _____ Address _____ Phone No. _____

Are you in good health? ____ If no, explain _____

Do you have an existing illness? ____ If yes, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much _____

Are you taking any medication, pills or drugs? _____ If so, please list _____

Do you now have or have you had any of the following? ____ If yes, describe under remarks _____

	Yes	No		Yes	No
1. Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
2. High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	14. Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	16. Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Allergy to (a) Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	19. (b) Other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	20. (c) Local Anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	21. (d) Other.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Tumor History.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	23. HIV.....	<input type="checkbox"/>	<input type="checkbox"/>

00Who referred you to our office?

First name Last name

Address

Phone number