**  
MEDICAL HISTORY**

**NAME:**

Please answer the following questions as accurately as possible. Circle yes or no, if you are not sure of the answer put a question mark next to the question.

**DENTAL HISTORY**

Dentist’s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have regular dental appointments? Yes No
2. Have you had any trouble with previous dental treatments? Yes No
3. Do you think saving your teeth is a waste of time? Yes No
4. Do you have any lumps or sores in your mouth now? Yes No
5. Have you ever had lumps or sores in your mouth before? Yes No
6. Do you have pain in the teeth, jaws, or head? Yes No
7. Have you ever had pain in your teeth, jaws or head? Yes No
8. Are there any dental problems that run in the family? Yes No

**MEDICAL HISTORY**

1. Have you ever had any problems with your heart or blood vessels? Yes No
2. Do you get chest pain? Yes No
3. Have you ever had rheumatic fever? Yes No
4. Do you have high blood pressure? Yes No
5. Have you ever been told you have an abnormal sound in your heart? Yes No
6. Do you have a pacemaker or defibrillator? Yes No
7. Have you ever had tuberculosis or emphysema? Yes No
8. Have you ever had asthma or hay fever? Yes No
9. Do you get shortness of breath when lying down or when climbing stairs Yes No
10. Do you have problems with your bowel movements? Yes No
11. Have you gained or lost weight recently? Yes No
12. Have you ever had hepatitis? Yes No
13. Do you have HIV/ AIDS? Yes No
14. Have you ever had ulcers of your stomach or intestines? Yes No
15. Have you ever had thyroid problems? Yes No
16. Have you or any member of your family had diabetes? Yes No
17. Are you pregnant? Yes No
18. Have you ever had any kidney or bladder problems? Yes No
19. Have you ever had any trouble with your glands? Yes No
20. Have you ever had syphilis, gonorrhea or any other venereal disease? Yes No
21. Have you ever passed blood in your urine? Yes No
22. Have you ever bled excessively following tooth extraction or a cut? Yes No
23. Have you ever had a blood transfusion? Why? Yes No
24. Are you on blood thinners? Yes No
25. Have you ever had problems with your blood? Yes No
26. Do you have frequent fractures of dislocations of bones? Yes No
27. Have you ever had joint replacement surgery? Yes No
28. Do you have any joint or muscle pain? Yes No
29. Do you suffer from frequent or severe headaches? Yes No
30. Have you ever had problems with local or general anesthesia? Yes No
31. Have you ever taken medication for an emotional problem? Yes No
32. Have you or anyone in the family ever had fits, seizures, or convulsions? Yes No
33. Have you ever had a skin disease? Yes No
34. Do you have any eye problems? Yes No
35. Do you have any ear problems? Yes No
36. Do you have any nose problems? Yes No
37. Do you have any allergies? Yes No
38. Have you ever had any unusual reactions to medical treatment? Yes No
39. Are there any diseases or medical problems that run in the family? Yes No
40. Do you smoke or drink? Yes No
41. Have you ever been hospitalized? Yes No
42. Are you taking any prescription medications or non-prescription drugs? Yes No

**COMMENTS ON ANY OF THE QUESTIONS:**(Please indicate reason for any “YES” answers for #’s 2 – 51)

**BLOOD PRESSURE:** (to be taken day of Workshop)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_