# PATIENT MEDICAL HISTORY

**Please place a mark on "Yes" or "No" to indicate if you have had any of the following:**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Cardiac Pacemaker | ❑ | ❑ | Radiation/Chemo |
| ❑ | ❑ | Low Blood Pressure | ❑ | ❑ | Heart Murmur | ❑ | ❑ | Glaucoma |
| ❑ | ❑ | Swollen Ankles | ❑ | ❑ | Angina | ❑ | ❑ | Recent Weight Loss |
| ❑ | ❑ | Rheumatic Fever | ❑ | ❑ | Frequently Tired | ❑ | ❑ | Liver Disease |
| ❑ | ❑ | Fainting/Seizures | ❑ | ❑ | Anemia | ❑ | ❑ | Heart Disease/Trouble |
| ❑ | ❑ | Asthma | ❑ | ❑ | Emphysema | ❑ | ❑ | Respiratory Problems |
| ❑ | ❑ | Heart Attack | ❑ | ❑ | Cancer | ❑ | ❑ | Mitral Valve Prolapse |
| ❑ | ❑ | Epilepsy/Seizures | ❑ | ❑ | Arthritis/Rheumatism | ❑ | ❑ | Sinus Trouble |
| ❑ | ❑ | Leukemia | ❑ | ❑ | Joint Replacement | ❑ | ❑ | Hay Fever/Allergies |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Hepatitis/Jaundice | ❑ | ❑ | Stroke |
| ❑ | ❑ | Kidney Diseases | ❑ | ❑ | Sexually Trans. Disease | **Women:** | | |
| ❑ | ❑ | AIDS / HIV infection | ❑ | ❑ | Stomach Troubles/Ulcers | ❑ | ❑ | Are you pregnant? |
| ❑ | ❑ | Thyroid Problem | | | | ❑ | ❑ | Breast-feeding? |
| ❑ | ❑ | Tuberculosis | ❑ | ❑ | Chest Pains | ❑ | ❑ | Birth Control Pills? |
| | | | ❑ | ❑ | Easily Winded | | | |

**Allergies:**

| Yes | No | |
|---|---|---|
| ❑ | ❑ | Aspirin |
| ❑ | ❑ | Local Anesthetic |
| ❑ | ❑ | Barbituates |
| ❑ | ❑ | Penicillin |
| ❑ | ❑ | Codeine |
| ❑ | ❑ | Sulfa |
| ❑ | ❑ | Iodine |
| ❑ | ❑ | Latex |
| ❑ | ❑ | Sedatives |

Please list any other allergies: _____

Name of Medical Doctor:_____Date of Last Visit:_____

Are you currently under medical treatment?_____ If yes, what?_____

Have you ever been hospitalized for any surgical operation or serious illness? _____ If yes, what?

_____

List medications you are currently taking:_____

_____

Pharmacy Name_____ Pharmacy Phone_____

Do you use tobacco?_____ Do you use alcohol?_____ Do you use cocaine or other drugs?_____

## Patient dental history

| Yes | No | |
|---|---|---|
| ❑ | ❑ | Do your gums bleed while brushing or flossing? |
| ❑ | ❑ | Are your teeth sensitive to hot or cold liquids/foods? |
| ❑ | ❑ | Are your teeth sensitive to sweet or sour liquids/foods? |
| ❑ | ❑ | Do you feel pain to any of your teeth? |
| ❑ | ❑ | Have you had any head, neck or jaw injuries? |
| ❑ | ❑ | Do you bite your lips or cheeks frequently? |
| ❑ | ❑ | Have you ever had any difficult extractions? |
| ❑ | ❑ | Have you ever had prolonged bleeding following extractions? |
| ❑ | ❑ | Have you had orthodontic work (braces)? |
| ❑ | ❑ | Have you ever had instruction on the correct method of brushing and flossing your teeth? |
| ❑ | ❑ | Have you ever had any instructions on the care of your gums? |
| ❑ | ❑ | Have you ever been diagnosed with a gum disease or had any periodontal treatment? |

**Have you ever experienced any of the following**:

| | | |
|---|---|---|
| ❑ | ❑ | Problems in your jaw? |
| ❑ | ❑ | Clicking? |
| ❑ | ❑ | Pain (joint, ear, side of face?) |
| ❑ | ❑ | Difficulty in opening or closing? |
| ❑ | ❑ | Difficulty in chewing? |
| ❑ | ❑ | Do you have frequent headaches? |
| ❑ | ❑ | Do you clench or grind your teeth? |

## Signature

***I certify that I have read and I understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.***

**X_____ (Patient, Parent, or Guardian) Date:_____**

Please print patient's name:_____Patient's Birthdate:_____

James J. Hur, D.D.S. 1402 36th Street, SW Wyoming, MI 49509 TEL (616) 534-3362