Medical Health History

Dr. R. Michael Whitaker DDS

Patient Information

Date: ______________________ Email Address: ______________________
First Name: ______________________ Last Name: ______________________ Middle Initial: ______
Mailing Address: ______________________ City: ______________________ Zip Code: ________ State: ____
Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ______________________
Social Security Number: ______________________ Date Of Birth: ______________________ □ Male □ Female
□ Single □ Married □ Divorced □ Widowed Name of Spouse______________________ Height____ Weight ____
Employer: ______________________ Occupation: ______________________
If you are completing this form for another person, what is your relationship to that person? ______________________
How did you hear about us? □ Friend or Relative, name______________ □ Phone Book □ Other ______________________

Insurance Information

Name of Insured: ______________________ Birthday: ______________________
Employer of Insured: ______________________ Social Security Number: ______________________
Name of Insurance Company: ______________________
Group or Contract Number: ______________________

Dental Health

How often do you brush your teeth? ______________ What texture tooth brush do you use? □ Soft □ Medium □ Hard
Are your teeth sensitive to pressure, heat, cold, sweet, or sour foods or liquids? ______________________
Do any of your teeth ache or feel pain? ______________________
Does food become caught between any of your teeth? ______________________
Have you noticed any shifting or loosening of your teeth? ______________________
Have you noticed any sores, lumps, or tumors in or near your mouth, if so please describe. ______________________
Have you experienced any clicking, pain, or difficulty when opening or closing your jaws? ______________________
Do you have frequent headaches? ______________________ Do you clench or grind your teeth? ______________________
Do you bite your lips or cheeks frequently? ______________ Have you ever had any head, neck or jaw injuries? ______________
Are you happy with your teeth and your smile? ______________________
Is there anything you wish you could change about your smile or teeth? ______________________
New Patients Only When is the last time you saw a Dentist?______________________

Medical Health

Are you under the care of a physician? __________ Your Physician's name? ______________________
Has your physical health changed in the previous year? □Yes □ No If yes, Please explain ______________________
Have you ever been hospitalized or had an operation in the past 5 years? □Yes □ No If yes, Please explain ______________________
Is your work, activity or diet restricted by the advice of your physician? □Yes □ No If yes, Please explain ______________________

What is your normal blood pressure?__________ Do your wear contact lens? □Yes □ No

Please list any medications you are currently taking including non-prescription medicine, vitamins, antacids, aspirin, or birth control pills. ______________________

Are you **ALLERGIC** to any of the following? □ Aspirin □ Penicillin □ Codeine □ Latex □ Local Anesthetics □ Metal
Any other allergies □ Yes □ No If yes, Please explain:______________________

Do you use tobacco? If yes, please list type, frequency and quantity. □Yes □ No ______________________
Do you use alcohol? If yes, please list type, frequency and quantity. □Yes □ No ______________________
Do you use cocaine or street drugs? If yes, please list type, frequency and quantity. □Yes □ No ______________________

*Medications that are used in routine dental treatment may interact with both prescription and street or illegal drugs. These reactions may result in severe complications. It is extremely important that you inform Dr. Whitaker or Susan, the office manager of any drugs you currently use or may have taken. All information on this form is CONFIDENTIAL.

Medical Health

Have you ever been treated for or do you have any of the following conditions? If yes, please check mark and describe.

□ Abnormal Blood Pressure
□ AIDS/HIV Positive
□ Allergies
□ Alzheimer's disease
□ Anemia
□ Angina
□ Arthritis
□ Artificial Joint Implant
□ Artery Problems
□ Asthma
□ Blood Disease
□ Blood Producing Cough
□ Breathing Problems
□ Bruise Easily
□ Cancer
□ Cardiac Pacemaker
□ Chemotherapy
□ Surgery for Cancer
□ Chest Pains on Exertion
□ Chronic Cough
□ Cold Sores/Fever Blisters
□ Congenital Heart Disease
□ Diabetes
□ Drug Addiction
□ Easily Winded
□ Emotional Problems
□ Emphysema
□ Epilepsy
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/Dizziness
□ Frequent Urination
□ Frequent Headaches
□ Genital Herpes
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure
□ Heart Defect
□ Heart Murmur
□ Heart Pace Maker
□ Heart Surgery
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A, B, or C
□ Headaches
□ Herpes
□ High Blood Pressure
□ Hives or Rash
□ Hypoglycemia
□ Immune System Abnormalities
□ Intestinal Disease
□ Irregular Heartbeat
□ Jaundice
□ Kidney Disease
□ Leukemia
□ Liver Disease
□ Mitral Valve Problems
□ Neurological Disorder
□ Pain in Jaw Joints
□ Parathyroid Problems
□ Psychiatric Care
□ Radiation treatments
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Seizures/Convulsions
□ Sexually Transmitted Disease
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Slowness to Heal
□ Spina Bifida
□ Stomach Disease
□ Stroke
□ Swollen Lymph Glands
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Other Serious Illness

Please Explain:_______

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Are you taking medication for bone loss? □ Yes □ No
Any recurrent illness not mentioned above? ____________________
Please describe any condition marked above____________________

Women, are you:
Pregnant? □ Yes □ No If yes, number of months__________
Nursing? □ Yes □ No
Taking birth control pills or Depo shot? □ Yes □ No

I certify that I have read and understand this form. I acknowledge that my questions, if any, about the inquiries set forth on this form have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I have made in the completion of this form. I understand that all information on this form is confidential.

______________________________ Date____________________
Signature of Patient or Guardian