green tree dental | Joseph P. Schmidt, DDS

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you been hospitalized in the past 5 years (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Please list other medications you are taking:
_____
_____

Have you ever had any of the following?

Chest Pains_____YES/NO	Shortness of Breath _____YES/NO	Hives/Skin Rashes_____YES/NO
Heart Failure _____YES/NO	Ulcers_____YES/NO	Alcoholism_____YES/NO
Heart Disease_____YES/NO	Mental Health Issues_____YES/NO	Drug Addiction_____YES/NO
Heart Attack_____YES/NO	Psychiatric Treatment_____YES/NO	Glaucoma_____YES/NO
Heart Problems_____YES/NO	Fainting/Dizziness_____YES/NO	Steroid Treatment_____YES/NO
Angina Pectoris_____YES/NO	Eating Disorder_____YES/NO	Arthritis_____YES/NO
Heart Surgery_____YES/NO	Emphysema/COPD_____YES/NO	Epilepsy/Seizures_____YES/NO
Mitral Valve Prolapse___YES/NO	Persistent Cough_____YES/NO	Diabetes_____YES/NO
Hypertension_____YES/NO	Tuberculosis_____YES/NO	Birth Defects_____YES/NO
Heart Murmur_____YES/NO	Asthma_____YES/NO	HIV+, AIDS_____YES/NO
Rheumatic Fever_____YES/NO	Hepatitis A, B, C, D_____YES/NO	Hay Fever_____YES/NO
Pacemaker_____YES/NO	Liver Disease_____YES/NO	Tobacco Products_____YES/NO
Artificial Heart Valve___YES/NO	Sinus Trouble_____YES/NO	Stroke_____YES/NO

Sickle Cell Disease_____YES/NO	Bruise Easily_____YES/NO	Cold Sores_____YES/NO
Jaundice_____YES/NO	Artificial Joints_____YES/NO	Cancer_____YES/NO
Kidney Trouble_____YES/NO	Thyroid Disease_____YES/NO	Radiation Therapy_____YES/NO
Anemia_____YES/NO	Excessive Bleeding_____YES/NO	Chemotherapy_____YES/NO
Blood Transfusion_____YES/NO	Sexually Transmitted Disease__YES/NO	Trasplant_____YES/NO
Snore at night_____YES/NO	Other_____	
Sleep with CPAP/BiPAP__YES/NO	_____	

Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name / location:_____
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking/popping in jaw joint	Yes No		
Pain in or around your ears	Yes No	Swelling	Bleeding Gums
Difficulty opening or closing	Yes No	Bad Taste	Bad Breath
Difficulty chewing	Yes No	Food Catching	Tooth Pain
History of trauma to jaw or face	Yes No	Clenching	Grinding
Diagnosis of TMJ/TMD	Yes No	Other: _____	

Sensitivity to: Hot Cold Sweets Biting

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date_____

Doctor's Signature_____

Doctor's Notes: