M. VERONICA PUNLA SMITH DDS
2215 OREGON STREET
OSHKOSH, WI 54902
920.231.8120

PATIENT MEDICAL HISTORY

Patient's Name: _____ Birthdate: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____

If filling out for another person, what is your relationship to that person? _____

Do you have or have you ever had any of the following diseases or problems? (Please circle Y or N)

Artificial Joints	Y/N	Stroke	Y/N	Rheumatic Fever	Y/N
Anemia	Y/N	Jaundice	Y/N	Epilepsy/Seizures	Y/N
HIV Positive/AIDS	Y/N	STD	Y/N	Blood in Saliva	Y/N
Diabetes	Y/N	Arthritis	Y/N	TB	Y/N
Hepatitis	Y/N	Severe Weight loss	Y/N	Low Blood Pressure	Y/N
Blood Transfusions	Y/N	Persistent Cough	Y/N	Heart Murmur	Y/N
Night Sweats	Y/N	High Blood Pressure	Y/N	Intestinal Disease	Y/N
Heart Failure	Y/N	Pacemaker	Y/N	Stomach Disease	Y/N
Heart Ailment	Y/N	Respiratory Disease	Y/N	HPV	Y/N
Kidney Disease	Y/N	Blood Disease	Y/N	Thyroid Disease	Y/N
Liver Disease	Y/N	Radiation Treatments	Y/N		
Estrogen Replacement	Y/N	Emphysema/Asthma	Y/N		
Cancer	Y/N	Type _____ When Diagnosed _____			

Have you ever taken bisphosphonate medication? (ie: Fosamax, Actonel, Boniva) Y/N When? _____
Do you use birth control medications (if applicable)? Y/N
Are you pregnant or could you be (if applicable)? Y/N
Are you nursing (if applicable)? Y/N
Have you had any wounds heal slowly? Y/N
Do you have a history of fainting or dizziness? Y/N
Have you had psychiatric treatment? If so, what? Y/N _____
Do you have disease or condition not listed? If yes list. Y/N _____
Are you under medical treatment now? Y/N _____
Do you smoke or chew tobacco? Y/N _____
Date of last physical: _____ Physician's Name: _____
Are you allergic to or have had any adverse reactions to any medications, anesthetics, metals or latex?
Y/N If yes, please list: _____

Have you had any major surgeries? Y/N If yes, please list: _____
_____

PATIENT DENTAL HISTORY

Have you ever had Novocaine/Lidocaine anesthetic? (numbing of area during dentistry)	Y/N
Do you have any pain in or near your ear?	Y/N
Does any part of your mouth hurt when clenched?	Y/N
Do you habitually clench your teeth at night or during the day?	Y/N
Have you had any difficult tooth extractions in the past?	Y/N
Any prolonged bleeding following extractions in the past?	Y/N
Do you need to take an antibiotic before dental appointments?	Y/N

Please list any drugs, medications, or herbal supplements you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AN ACCURATE

Patient/Guardian Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

MEDICAL HISTORY UPDATES: (Office Use Only)

DATE	BP	COMMENTS/MED UPDATES	SIGNATURE/INITIALS