willwagner dmd
FAMILY AND COSMETIC DENTISTRY

Patient Medical History

Please answer all of the following questions to the best of your ability.

Physician_____ Physician's Phone #_____

1. Are you under the care of a physician at this time? YES NO
2. Have you been hospitalized for any surgery or serious illness within last 5 years? YES NO
   If yes, please explain_____
3. Are you taking any medication(s)? YES NO
   If yes, please list_____
4. Are you allergic to any medication(s)?
   If yes, please list_____
5. Do you use tobacco? YES NO
6. *Women Only* Are you pregnant? YES NO
   Are you nursing? YES NO
7. **Do you have or have you had any of the following?** YES NO

AIDS / HIV	Y N	Glaucoma	Y N	Respiratory Problems	Y N
Anemia	Y N	Hay Fever / Allergies	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Heart Attack	Y N	Seizures	Y N
Asthma	Y N	Hepatitis	Y N	Sinus Trouble	Y N
Bleeding Disorder	Y N	High Blood Pressure	Y N	Sleep Apnea	Y N
Cancer	Y N	Joint replacement or implant	Y N	STD's	Y N
Chest Pain / Angina	Y N	Kidney Disease	Y N	Stroke	Y N
Congenital Heart Defect	Y N	Liver Disease	Y N	Thyroid Problems	Y N
Diabetes	Y N	Low Blood Pressure	Y N	Tuberculosis	Y N
Emphysema	Y N	Radiation Therapy	Y N	Other_____	Y N

Patient Dental History

Previous Dentist Name & Location_____

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to hot or cold liquid/foods?	Yes	No
Do you feel pain in any of your teeth?	Yes	No
Do you clench or grind your teeth?	Yes	No
Have you ever had any prolonged bleeding after extractions?	Yes	No
Have you had any orthodontic treatment (braces, retainer, etc.)?	Yes	No
Have you ever had any head, neck, or jaw injuries?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No
Do you wear dentures or partials?	Yes	No

If yes date of placement_____

Have you experienced any of the following problems in your jaw?

- Clicking Yes No
- Pain (joint, ear, side of face) Yes No
- Difficulty opening or closing Yes No
- Difficulty chewing Yes No
- Frequent headaches Yes No

I, the undersigned, attest that to the best of my knowledge, the above information is true.

Patient Signature_____Date_____

Patient Name (Print)_____