MEDICINE WHEEL DENTAL

HEALTH HISTORY

ALL INFORMATION GIVEN IS CONFIDENTIAL

NAME:_______________________________ **DATE:**_____________________ **AGE:**________

DATE OF BIRTH:______________________ **M**________ **F**________

SPOUSE/PARENT:____

DO YOU HAVE A BIO-COMPATIBILITY TEST? **YES**__________ **NO**__________

IF YES, YEAR AND FROM WHOM?____

HAVE YOU BEEN EXAMINED BY A PHYSICIAN WITHIN THE LAST (CIRCLE ONE) 1-3 MONTHS 6 MONTHS-YEAR NEVER

PHYSICIAN'S NAME____

WHAT MEDICATIONS HAVE YOU TAKEN IN THE LAST YEAR (INCLUDING BIRTH CONTROL PILLS AND VITAMINS)__________________

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	PAST	CURRENT	NO		PAST	
ALLERGIES TO MEDICATIONS	⬭	⬭	⬭	URINARY OR GENITAL PROBLEMS	⬭	⬭
IF CURRENT PLEASE STATE				VENEREAL/SEXUALLY TRANSMITTED DISEASE	⬭	⬭
ALLERGIES	⬭	⬭	⬭	IF CURRENT, WHAT TYPE		
HIVES/SKIN RASHES	⬭	⬭	⬭	KIDNEY OR BLADDER PROBLEMS	⬭	⬭
HEART OR CIRCULATION PROBLEMS	⬭	⬭	⬭	EXCESSIVE URINATION,PAIN,POOR CONTROL	⬭	⬭
HIGH/LOW BLOOD PRESSURE (CIRCLE)	⬭	⬭	⬭	DECREASED FORCE OF URINATION	⬭	⬭
HEART MURMUR	⬭	⬭	⬭	BLOOD IN URINE	⬭	⬭
MITRAL VALVE PROLAPSE	⬭	⬭	⬭	PROSTATE PROBLEMS	⬭	⬭
HEART ATTACK	⬭	⬭	⬭	WOMEN: ARE YOU PREGNANT?	YES	
STROKE	⬭	⬭	⬭	NUMBER OF PREGNANCIES		
FAINTING SPELLS	⬭	⬭	⬭	NUMBER OF LIVE BIRTHS		
BLOOD TRANSFUSION	⬭	⬭	⬭	DIFFICULTIES WITH CHILDBIRTH?	⬭	⬭
PROLONGED BLEEDING FROM CUTS/EXTRACTIONS	⬭	⬭	⬭	PMS (MODERATE OR SEVERE?)	⬭	⬭
ANEMIA, BLOOD DISORDERS	⬭	⬭	⬭	**NEUROLOGICAL PROBLEMS**		
HIV, ARC, AIDS (CIRCLE)	⬭	⬭	⬭	EPILEPSY/CONVULSIONS OR SEIZURES	⬭	⬭
SWOLLEN ANKLES	⬭	⬭	⬭	BLACKOUTS OR FAINTING SPELLS	⬭	⬭
HEART PALPITATIONS	⬭	⬭	⬭	NUMBNESS/TIGHTNESS SENSATIONS	⬭	⬭
BRUISE EASILY	⬭	⬭	⬭	TREMORS	⬭	⬭
RESPIRATORY/BREATHING PROBLEMS				**EYE PROBLEMS**		
ASTHMA/HAY FEVER	⬭	⬭	⬭	CONTACT LENSES/GLASSES	⬭	⬭
SINUS PROBLEMS	⬭	⬭	⬭	EYE PAIN	⬭	⬭
LUNG DISEASE	⬭	⬭	⬭	BLURRED OR DOUBLE VISION	⬭	⬭
TUBERCULOSIS (T.B.)	⬭	⬭	⬭	**EAR PROBLEMS**		
CHEST PAINS, OR SHORTNESS OF BREATH W/EXTRACTIONS	⬭	⬭	⬭	DIFFICULTY HEARING	⬭	⬭
PNEUMONIA	⬭	⬭	⬭	PAIN IN/AROUND EARS	⬭	⬭
CHRONIC COUGH	⬭	⬭	⬭	RINGING OR HIGH PITCHED SOUNDS	⬭	⬭
EMPHYSEMA	⬭	⬭	⬭	EAR INFECTIONS	⬭	⬭
GASTRO INTESTINAL PROBLEMS				DIZZINESS OR LOSS OF BALANCE	⬭	⬭
UNEXPLAINED WEIGHT LOSS	⬭	⬭	⬭	**THROAT PROBLEMS**		

	PAST	CURRENT	NO
CONSTIPATION/ DIARRHEA			
JAUNDICE/LIVER PROBLEMS			
CHRONIC ABDOMINAL PAIN			
COLITIS/ULCER/NERVOUS STOMACH			
DIFFICULTY SWALLOWING			
LOSS OF APPETITE			
HEMORRHOIDS			
MOUTH AND TEETH PROBLEMS			
SENSITIVITY TO COLD,HEAT,SWEETS,PRESSURE			
HERPES, COLD OR CANKER SORES			
BLEEDING GUMS WHILE BRUSHING/FLOSSING			
FOOD PACKS BETWEEN TEETH			
FLOSS TEARS OR HARD TO USE			
FLOSS DAILY			
TENDER, SWOLLEN GUMS			
PREVIOUS GUM TREATMENT			
BURNING TONGUE			
METALLIC TASTE IN MOUTH			
BAD BREATH/UNPLEASANT TASTE IN MOUTH			
SWELLING, LUMPS IN MOUTH			
TOOTHACHE			
SORE/DRY MOUTH			
PROBLEMS WITH DENTAL CARE			
JAW PROBLEMS			
POPPING OR CLICKING WHEN CHEWING			
HARD TO CHEW FOOD			
JAW STIFF OR HARD TO OPEN (CIRCLE)			
JAW LOCKS OPEN/CLOSED			
WAKE UP WITH TIGHT JAW			
DO YOU CLENCH/GRIND YOUR TEETH (CIRCLE)			
DO YOU TEND TO KEEP YOUR TEETH TOUCHING			
ANY INJURIES TO YOUR FACE OR JAW			
HAVE YOU EVER HAD ORTHODONTICS			
HEADACHES OR MIGRAINES (CIRCLE)			
HOW OFTEN?			
MUSCULOSKELETAL: ANY BODY ACHES			
CHRONIC NECK OR UPPER SHOULDER TENSION			
BACKACHES			
ANY RESTRICTION OF RANGE OF MOTION			
TIGHTNESS OR STIFFNESS			
ARTHRITIS/PAINFUL OR SWOLLEN JOINTS			
HIP OR SHOULDER PROBLEMS			
OTHER PROBLEMS			
HISTORY OF ANY PROLONGED ILLNESS			
SWOLLEN OR TENDER AREAS			
HEPATITIS (INFECTIOUS/SERUM)			
IF CURRENT WHAT TYPE?			
MONONUCLEOSIS			
LOW ENERGY			

	PAST
SWALLOWING PROBLEMS OR CHRONIC HOARSENESS	
FREQUENT SORE THROAT	
ENDOCRINE PROBLEMS	
EXCESSIVE THIRST	
DIABETES	
HYPOGLYCEMIA/LOW BLOOD SUGAR	
RECOVERY GROUP	
FEARS OR PHOBIAS	
DIFFICULTY SLEEPING	
MEMORY LOSS	
MEASLES	
GERMAN MEASLES	
SCARLET FEVER	
POLIO	
CHICKEN POX	
REACTIONS TO INOCULATIONS	
DO YOU TAKE ASPIRIN,TYLENOL OR ADVIL	
HOW OFTEN?	
MALARIA	
TYPHOID FEVER	
MUMPS	
RECREATIONAL DRUG USE	
ALCOHOL	
HOW OFTEN?	
SMOKING	
HOW MANY PER DAY?	
COFFEE OR TEA (CIRCLE)	
HOW MANY CUPS PER DAY?	
HISTORY OF STEROID USE	
DO YOU AVOID FATS/OILS/SUGAR (CIRCLE)	
IS THERE ANYTHING YOU'VE LEFT OUT?	
ANY SURGERIES OR OPERATIONS?	
ANY PINS, PLATES, ARTIFICIAL JOINTS/ARTIFICIAL VALV	
REPLACEMENT PARTS?	
PLEASE LIST PHYSICIANS AND WHAT THEY ARE TREAT	
PHYSICIANS NAME	CONDITION
DO YOU NEED TO BE PREMEDICATED	

PROBLEM WITH SKIN, HAIR OR NAILS	⬭	⬭	⬭	BEFORE DENTAL TREATMENT:	YES
EMOTIONAL PROBLEMS	⬭	⬭	⬭	IF YES, PLEASE INDICATE	
COLD OR NUMB HANDS OR FEET	⬭	⬭	⬭		
MOODINESS	⬭	⬭	⬭		
CHRONIC FATIGUE	⬭	⬭	⬭		
PROCRASTINATION	⬭	⬭	⬭		
CANCER/MALIGNANCIES	⬭	⬭	⬭		
ALCOHOLISM					

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAN
THAT THE INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF A
CHANGES IN MY MEDICAL STATUS.

PATIENT'S SIGNATURE

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CURRENT	NO
NO	

CURRENT	NO