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)_____
_____
_____

	PAST	CURRENT	NO
ALLERGIES TO MEDICATIONS	⬭	⬭	⬭
IF CURRENT PLEASE STATE			
ALLERGIES	⬭	⬭	⬭
HIVES/SKIN RASHES	⬭	⬭	⬭
HEART OR CIRCULATION PROBLEMS	⬭	⬭	⬭
HIGH/LOW BLOOD PRESSURE (CIRCLE)	⬭	⬭	⬭
HEART MURMUR	⬭	⬭	⬭
MITRAL VALVE PROLAPSE	⬭	⬭	⬭
HEART ATTACK	⬭	⬭	⬭
STROKE	⬭	⬭	⬭
FAINTING SPELLS	⬭	⬭	⬭
BLOOD TRANSFUSION	⬭	⬭	⬭
PROLONGED BLEEDING FROM CUTS/EXTRACTIONS	⬭	⬭	⬭
ANEMIA, BLOOD DISORDERS	⬭	⬭	⬭
HIV, ARC, AIDS (CIRCLE)	⬭	⬭	⬭
SWOLLEN ANKLES	⬭	⬭	⬭
HEART PALPITATIONS	⬭	⬭	⬭
BRUISE EASILY	⬭	⬭	⬭
RESPIRATORY/BREATHING PROBLEMS			
ASTHMA/HAY FEVER	⬭	⬭	⬭
SINUS PROBLEMS	⬭	⬭	⬭
LUNG DISEASE	⬭	⬭	⬭
TUBERCULOSIS (T.B.)	⬭	⬭	⬭
CHEST PAINS, OR SHORTNESS OF BREATH W/EXTRACTIONS	⬭	⬭	⬭
PNEUMONIA	⬭	⬭	⬭
CHRONIC COUGH	⬭	⬭	⬭
EMPHYSEMA	⬭	⬭	⬭
GASTRO INTESTINAL PROBLEMS			
UNEXPLAINED WEIGHT LOSS	⬭	⬭	⬭
CONSTIPATION/ DIARRHEA	⬭	⬭	⬭
JAUNDICE/LIVER PROBLEMS	⬭	⬭	⬭
CHRONIC ABDOMINAL PAIN	⬭	⬭	⬭
COLITIS/ULCER/NERVOUS STOMACH	⬭	⬭	⬭
DIFFICULTY SWALLOWING	⬭	⬭	⬭
LOSS OF APPETITE	⬭	⬭	⬭
HEMORRHOIDS	⬭	⬭	⬭

	PAST	CURRENT	NO
URINARY OR GENITAL PROBLEMS	⬭	⬭	⬭
VENEREAL/SEXUALLY TRANSMITTED DISEASE	⬭	⬭	⬭
IF CURRENT, WHAT TYPE			
KIDNEY OR BLADDER PROBLEMS	⬭	⬭	⬭
EXCESSIVE URINATION,PAIN,POOR CONTROL	⬭	⬭	⬭
DECREASED FORCE OF URINATION	⬭	⬭	⬭
BLOOD IN URINE	⬭	⬭	⬭
PROSTATE PROBLEMS	⬭	⬭	⬭
WOMEN: ARE YOU PREGNANT?	YES	NO	
NUMBER OF PREGNANCIES			
NUMBER OF LIVE BIRTHS			
DIFFICULTIES WITH CHILDBIRTH?	⬭	⬭	⬭
PMS (MODERATE OR SEVERE?)	⬭	⬭	⬭
NEUROLOGICAL PROBLEMS			
EPILEPSY/CONVULSIONS OR SEIZURES	⬭	⬭	⬭
BLACKOUTS OR FAINTING SPELLS	⬭	⬭	⬭
NUMBNESS/TIGHTNESS SENSATIONS	⬭	⬭	⬭
TREMORS	⬭	⬭	⬭
EYE PROBLEMS			
CONTACT LENSES/GLASSES	⬭	⬭	⬭
EYE PAIN	⬭	⬭	⬭
BLURRED OR DOUBLE VISION	⬭	⬭	⬭
EAR PROBLEMS			
DIFFICULTY HEARING	⬭	⬭	⬭
PAIN IN/AROUND EARS	⬭	⬭	⬭
RINGING OR HIGH PITCHED SOUNDS	⬭	⬭	⬭
EAR INFECTIONS	⬭	⬭	⬭
DIZZINESS OR LOSS OF BALANCE	⬭	⬭	⬭
THROAT PROBLEMS			
SWALLOWING PROBLEMS OR CHRONIC HOARSENESS	⬭	⬭	⬭
FREQUENT SORE THROAT	⬭	⬭	⬭
ENDOCRINE PROBLEMS			
EXCESSIVE THIRST	⬭	⬭	⬭
DIABETES	⬭	⬭	⬭
HYPOGLYCEMIA/LOW BLOOD SUGAR	⬭	⬭	⬭

	PAST	CURRENT	NO
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	⬭	⬭	⬭
PROBLEM WITH SKIN, HAIR OR NAILS	⬭	⬭	⬭
EMOTIONAL PROBLEMS	⬭	⬭	⬭
COLD OR NUMB HANDS OR FEET	⬭	⬭	⬭
MOODINESS	⬭	⬭	⬭
CHRONIC FATIGUE	⬭	⬭	⬭
PROCRASTINATION	⬭	⬭	⬭
CANCER/MALIGNANCIES	⬭	⬭	⬭
ALCOHOLISM	⬭	⬭	⬭

	PAST	CURRENT	NO
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 VALVES OR			
REPLACEMENT PARTS?			
PLEASE LIST PHYSICIANS AND WHAT THEY ARE TREATING YOU FOR?			
PHYSICIANS NAME	CONDITION OR ILLNESS		
DO YOU NEED TO BE PREMEDICATED			
BEFORE DENTAL TREATMENT:	YES	NO	
IF YES, PLEASE INDICATE			

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

PATIENT'S SIGNATURE