Joseph A. Mika, DDS

MEDICAL HISTORY

Name_____ Birth Date_____

Pharmacy_____ Pharmacy Phone Number_____

Although dental professionals primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physician's care right now? ○Yes○No If yes, please explain: _____
Have you ever been hospitalized or had a major surgery? ○Yes○No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○Yes○No If yes, please explain: _____
Do you use tobacco? ○Yes○No
Do you use controlled substances? ○Yes○No
Are you taking any medications, pills or drugs? ○Yes○No If yes, please explain:_____

_____

Women: Are you
Pregnant/Trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex
☐ Other If yes, please explain:

Do you have, or have you had, any of the following? Please check all that apply.

☐AIDS/HIV Positive	☐Convulsion	☐Heart Murmur	☐Pain in Jaws
☐Anemia	☐Dementia	☐Heart Pace Maker	☐Poor Memory
☐Angina	☐Diabetes	☐Heart Trouble/Disease	☐Psychiatric Care
☐Arthritis/Gout	☐Drug Addiction	☐Hemophilia	☐Radiation Treatments
☐Artificial Heart Valve	☐Easily Winded	☐Hepatitis	☐Renal Dialysis
☐Artificial Joint	☐Emphysema	☐Herpes	☐Rheumatic Fever
☐Asthma	☐Epilepsy or Seizures	☐High Blood Pressure	☐Rheumatism
☐Blood Disease	☐Excessive Bleeding	☐Hypoglycemia	☐Sinus Trouble
☐Blood Transfusion	☐Daytime Sleepiness	☐Irregular Heart Beat	☐Snoring
☐Breathing Problem	☐Fainting Spells/Dizziness	☐Kidney Problems	☐Stomach/Intestinal Disease
☐Bruise Easily	☐Fragmented Light Sleep	☐Leukemia	☐Stroke
☐Cancer	☐Frequent Diarrhea	☐Liver Disease	☐Thyroid Disease
☐Chemotherapy	☐Frequent Headaches	☐Low Blood Pressure	☐Tuberculosis
☐Chest Pains	☐GERD	☐Night Sweats	☐Tumors or Growths
☐Cold Sores/Fever Blisters	☐Glaucoma	☐Mitral Valve Prolapse	☐Venereal Disease
☐Congenital Heart Disorder	☐Heart Attack/Failure	☐Morning Headaches	☐Yellow Jaundice

If you have had a serious illness not listed above, please explain:

Are you happy with the appearance of your teeth? ○Yes ○No
Do your teeth hurt when you brush your teeth? ○Yes ○No
Is any part of your mouth sensitive to irritants (hot, cold, sweets)? ○Yes ○No
Does any part of your mouth hurt when clenched? ○Yes ○No
Do you have pain in your jaws, face or mouth? ○Yes ○No
Do your gums bleed when you brush or floss your teeth? ○Yes ○No
Do you have any unhealed injuries or inflamed areas in your mouth? ○Yes ○No
Do you have frequent "bad tastes" in your mouth? ○Yes ○No
Have you had prolonged bleeding after a dental extraction? ○Yes ○No
Have you ever had a TMJ disorder? ○Yes ○No
Do you clench or grind your teeth during any part of the day or night? ○Yes ○No
If you have a dental problem not listed above, please explain:

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the dental office of changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE_____