Medical History

The Dental Practice of
Robert W. Wheeler, D.D.S

"Combining the Art of Cosmetic Dentistry and Physiologic Occlusion"

1. Have you ever had:

2. Periodontal disease/gum treatment	☐ Yes	☐ No	6.Discomfort in your jaw joint(TMJ/TMD)	☐ Yes	☐ No
3. Orthodontic treatment	☐ Yes	☐ No	7.Your teeth ground or bite adjusted	☐ Yes	☐ No
4. Oral surgery	☐ Yes	☐ No	8.Serious injury to the mouth or head	☐ Yes	☐ No
5. A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe_____

Is there anything else about your past dental treatment that you would like us to know?

_____

Indicate which of the following you have had or have at present

AIDS/HIV	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Mitro Valve Prolapse	☐ Yes ☐ No
AlcoholAbuse	☐ Yes ☐ No	Drug Abuse	☐ Yes ☐ No	Nervous Disorders	☐ Yes ☐ No
Allergies/Hives	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Osteoperosis	☐ Yes ☐ No
Allergy to Metal	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Angina Pectoris	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Arteriosclerosis	☐ Yes ☐ No	Fainting/Dizzy Spells	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Growths/Tumors	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Head Injuries	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Failure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Transfer	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Heart Surgery	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Chronic Cough	☐ Yes ☐ No	Hepatitis (Indicate) A B C D	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cold Sores/ Blisters	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Codeine Allergy	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Latex Allergy	☐ Yes ☐ No
Developmentally Disabled	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Penicillin Allergy	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	OTHER:_____	
Difficulty Breathing	☐ Yes ☐ No	Mental Disorders	☐ Yes ☐ No		

9. Do you have any disease or allergy not listed? ☐ Yes ☐ No
   If yes, explain_____
10. Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No
    If yes, explain_____
11. Hospital or Physician's name _____ Phone_____
12. Hospital or Physician's City _____ State _____
13. Have you taken any medications or dugs in the last two years? ☐ Yes ☐ No
14. Are you currently taking any medications or drugs?
    (including regular doses of aspirin or over the counter medications ☐ Yes ☐ No
    If yes, please explain_____
15. Have you taken Bisphosphonates? ☐ Yes ☐ No
    If so, how long ago? _____
16. Have you been to the doctor to check for heart problems? ☐ Yes ☐ No
    If so, what are the problems?_____
17. Do you use tobacco ☐ Yes ☐ No 17. Do you use alcohol or any other controlled substance? ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No If yes, due date_____
Are you taking birth control pills? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No