Five Points Dental
Dr. Ronald K. Roessler
1529 Margaret St. Jacksonville, Fl 32204 (904)356-4880

Patient Name _____

MEDICAL HISTORY

1. When was your last physical examination? _____
2. Have there been any changes in your health? **YES / NO**
   If **YES**, please explain_____
3. Are you under the care of a physician**? YES / NO**
   If **YES**, please explain _____
4. Have you been hospitalized or had a serious illness within the last 5 years? **YES / NO**
   If **YES**, please explain _____

5. If you have had any of the following conditions, please check…

__HEART MURMUR __DIABETES
__TUBERCULOSIS __VENEREAL DISEASE
__KIDNEY TROUBLE __ARTHRITIS / RHEUMATISM
__ASTHMA / HAY FEVER __HIGH OR LOW BLOOD PRESSURE
__RADIATION THERAPY __RHEUMATIC FEVER / HEART PROBLEM
__FAINTING SPELLS __ABNORMAL BLEEDING / BLOOD DISORDERS
__HEPATITUS, JAUNDICE OR LIVER DISEASE INCLUDING HEPATITIS A, B, C, AND DELTA
__ANY JOINTS/ORGANS/BODY PARTS IN YOUR BODY REPLACED WITH ARTIFICIAL PARTS
If YES, please explain _____
__ARE YOU TAKING ANY MEDICATIONS FOR **OSTEOPOROSIS** OR BONE DISEASE?
If YES, please list medications _____
__DO YOU HAVE AIDS, A.R.C., OR ARE YOU HIV POSITIVE (**Please circle**)

6. Do you have any disease, condition or other problem that is not mentioned above? **YES / NO**
   If yes, please explain _____
7. Do you have any difficulty breathing through your nose? **YES / NO**
8. Are you currently taking any medication? **YES / NO**
   If **YES,** please list_____
9. Do you have any allergic reactions to any drugs or medications such as Aspirin, Penicillin, or Codeine? **YES / NO**
   If **YES**, please explain _____
10. Are you aware of any bumps in your mouth? **YES / NO**
11. Are you experiencing any dental problems at this time? **YES / NO**
    If **YES**, please explain _____
12. When was your last dental visit? _____
13. Have you had any of the following treatments? (**Please circle**)
    ORTHODONTICS, PERIODONTICS (Gum Disease), ENDODONTICS (Root Canal Therapy)
14. Do you experience any pain or clicking in your jaw, ear or facial muscles upon opening your mouth? **YES / NO**
15. Do your gums bleed? **YES / NO**
16. Do you grind or clench your teeth? **YES / NO**
17. Do you suffer from anxiety or gagging during dental procedures? **YES / NO**
18. Do you smoke, chew tobacco, or regularly use any other tobacco products? **YES/NO**
19. Are you allergic to latex? **YES/NO**

WOMEN ONLY:

1. Are you pregnant or is there a chance you could be? If **YES**, how many months? _____
2. Are you taking any birth control pills? **YES / NO**

Patient's (or Guardian's) Signature _____ **Date** _____

Reviewed By _____**Date**_____

Dr. Ronald K. Roessler