Dr. Mike Merkley, DDS

Medical History

MERKLEY DENTAL

Name ____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "Yes" response, leaving it blank will indicate a "No" response.

☐ AIDS/HIV positive
☐ Blood Thinners
☐ Hepatitis
☐ Premed Necessary
☐ Excessive Bleeding
☐ Cancer
☐ High Blood Pressure
☐ Pacemaker/Defibrillator
☐ Stroke
☐ Heart Surgery
☐ Asthma
☐ HPV
☐ Heart Murmur
☐ Nervous Disorder
☐ Sinus Problems
☐ Thyroid Disease
☐ Respiratory Problems
☐ Dizziness
☐ Liver Disease
☐ Rheumatic Fever
☐ Anemia
☐ Epilepsy
☐ Kidney Disease
☐ Radiation Treatment
☐ Ulcers
☐ Sleep Apnea
☐ Diabetes/Hypoglycemia
☐ Eating Disorder
☐ Intestinal Problems
☐ Acid Reflux/Heart Burn
☐ Tuberculosis
☐ Drug or Alcohol Addiction
☐ Arthritis
☐ Fainting
☐ Osteoporosis
☐ Stomach Problems
☐ Artificial Joints
☐ Heart Disease
☐ Mental Illness
☐ Rheumatism
☐ Auto Immune Disease
☐ Latex Allergy
☐ Allergies- Anesthetic
☐ Allergies - Hay fever
☐ Allergies- Metal
☐ Allergies- Medication
☐ Allergies - Other
____

☐ Are you taking any medications for osteoporosis/osteopenia ________________________________
☐ Ever been hospitalized (illness or injury) ____
☐ Presently being treated for any other illness ____
☐ A smoker or smoked previously/chewing tobacco
☐ Female: Taking birth control pills ☐ Currently Pregnant/nursing

If any conditions or alerts were selected above and need further clarification, please describe below:

____
____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and date of your most recent physical exam:

____
____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. ____

List all medications, drugs, pills, or herbal remedies, including regular dosages of aspirin.

____
____
____
____

Dr. Mike Merkley, DDS **Medical History** MERKLEY DENTAL

Name ____

Please answer the following **dental questions**:
YES NO

__________Have you had any unfavorable response to dental anesthetic?
__________Do you have teeth that are sensitive to hot, cold, sweets or pressure?
__________Do you have teeth that regularly get food trapped between them?
__________Do you have bleeding gums, loose teeth or any other gum problems?
__________Are you concerned with personal mouth odor?
__________Do you floss? If so how often? _________
__________Do you have problems with your jaw joint or any of the following symptoms: Headache, neck pain, facial pain, clicking or locking jaw, difficulty opening, or clenching or grinding. ____
____
__________Do you have a higher than normal anxiety about going to the dentist?
__________Are you missing any teeth? How long have they been missing?____________________
__________Would you like to know about teeth whitening?
__________Are you happy with the color of your fillings and crowns?
__________Are any of your teeth chipped or worn?
__________Do you have any dental implants? Who was the dentist? ________________________

Who was your previous dentist? When was your last visit? __________________________________
____

List any problems that you know of with your teeth? ____
____

How straight are your teeth? Would you like more information about straightening them?
____

By signing this form, You acknowledge that you have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are not other medical conditions or medications/allergies that have been not listed. I am aware that I must notify the practice of any further changes.

____ _________________
Signature Date