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*Adults & Children*

# Patient History Form

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

## Dental History

Patient's Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

How long have you been with this dentist? \_\_\_\_\_

## Medical History

Physician \_\_\_\_\_

General Health and Known Illnesses \_\_\_\_\_

Present Medication \_\_\_\_\_

Is there a possibility that you may be pregnant? No \_\_\_\_\_ Yes \_\_\_\_\_

Have you ever had an allergic reaction to medication? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please list medication \_\_\_\_\_

Have you ever had any of the following: Circle Yes or No

Asthma	No	Yes	HIV/Aids	No	Yes
Bleeding Disorders	No	Yes	High Blood Pressure	No	Yes
Cancer	No	Yes	Migraine/Frequent Headaches	No	Yes
Diabetes	No	Yes	Mental or Physical Disability	No	Yes
Epilepsy	No	Yes	Sinus Problems	No	Yes
Hepatitis	No	Yes	Heart Condition	No	Yes

Damaged heart valves (Mitral valve prolapse, artificial heart valve, heart murmur) No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, do you need to be premedicated? No \_\_\_\_\_ Yes \_\_\_\_\_