Name _____ D.O.B. _____ SS# _____

# Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ | ☐ | ☐ |
| 4. Do you use tobacco? | ☐ | ☐ |
| 5. Do you use controlled substances? | ☐ | ☐ |
| 6. Are you wearing contact lenses? | ☐ | ☐ |

| 8. Are you allergic to or have you had any reactions to the following? | Yes | No |
|---|---|---|
| Local Anesthetics (eg. novocaine) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list) _____ | ☐ | ☐ |

| 9. Women Only: | Yes | No |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |

7. Do you have or have you had any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease or Trouble | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Shortness of Breath | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever / Allergies | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Other _____ | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ | | | |

# Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking? | ☐ | ☐ |
| Pain (joint, ear, side of face)? | ☐ | ☐ |
| Difficulty in opening or closing? | ☐ | ☐ |
| Difficulty in chewing? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you had any orthodontic treatment? | ☐ | ☐ |
| 14. Do you wear dentures or partials? If yes, date of placement _____ | ☐ | ☐ |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 16. Do you like your smile? | ☐ | ☐ |
| 17. Does dental treatment make you nervous? | ☐ | ☐ |

# Authorization

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.*

X _____

*Signature of patient (or parent if minor)* *Date*