

PATIENT
NAME

PATIENT NAME _____	TODAY'S DATE _____
HOME ADDRESS _____	DATE OF BIRTH _____
_____	HOME PHONE _____
EMAIL _____	CELL PHONE _____
EMPLOYER _____	BUSINESS PHONE _____
INSURANCE CO. _____	SS#/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

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|---|--|---|---|---------------------------------------|----------------------------------|--|------------------------------------|--------------------------------------|--------------------------------------|---------------------------------|--|--|
| 1. Are you under medical treatment now? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 8. Are you allergic to or have you had any reactions to the following? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 2. Have you been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <table border="0"> <tr> <td><input type="checkbox"/> Local Anesthetics (e.g. Novocaine)</td> <td><input type="checkbox"/> Barbiturates</td> <td><input type="checkbox"/> Aspirin</td> </tr> <tr> <td><input type="checkbox"/> Penicillin or other antibiotics</td> <td><input type="checkbox"/> Sedatives</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Sulfa Drugs</td> <td><input type="checkbox"/> Iodine</td> <td></td> </tr> </table> | <input type="checkbox"/> Local Anesthetics (e.g. Novocaine) | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Iodine | | |
| <input type="checkbox"/> Local Anesthetics (e.g. Novocaine) | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Aspirin | | | | | | | | | | |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Other _____ | | | | | | | | | | |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Iodine | | | | | | | | | | | |
| 3. Are you taking any medication(s) including non-prescription medicine?
If yes, what medications are you taking?
_____ | <input type="checkbox"/> YES <input type="checkbox"/> NO | 9. WOMEN ONLY: | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> YES <input type="checkbox"/> NO | a.) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 5. Do you use tobacco? | <input type="checkbox"/> YES <input type="checkbox"/> NO | b.) Are you nursing? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 6. Do you use alcohol, cocaine, or other drugs? | <input type="checkbox"/> YES <input type="checkbox"/> NO | c.) Are you taking birth control pills? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 7. Are you wearing contact lenses? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |

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|--|--------------------------|--------------------------|---|--------------------------|--|--------------------------|
| 11. Do you have any of the following? | YES | NO | YES | NO | YES | NO |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Angina | <input type="checkbox"/> | <input type="checkbox"/> Hay Fever / Allergies | <input type="checkbox"/> |
| <input type="checkbox"/> Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Anemia | <input type="checkbox"/> | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> |
| <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Emphysema | <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> |
| <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> |
| <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> |
| <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> Other _____ | <input type="checkbox"/> |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Stomach Troubles / Ulcers | <input type="checkbox"/> | <input type="checkbox"/> _____ | <input type="checkbox"/> |

COMMENTS

Signature of Dentist _____ Date _____

PATIENT DENTAL HISTORY

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|---|--|---|--|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 8. Do you have frequent headaches? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 9. Do you clench or grind your teeth? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 12. Have you ever had any orthodontic treatment? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. Have you had any head, neck, or jaw injuries? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 13. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7. Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| a.) Clicking? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 15. Have you ever had instructions on the care of your gums? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| b.) Pain (joint, ear, side of face)? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| c.) Difficulty opening or closing? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| d.) Difficulty chewing? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

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.

SIGNATURE

X

Patient, Parent, or Guardian

Date _____