Patient Medical History

Name _____

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?.....		

7. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novacaine)……....		
Penicillin or any other antibiotics……..		
Sulfa drugs……....		
Barbiturates……....		
Sedatives……		
Iodine……		
Aspirin……		
Any metals (e.g. nickel, mercury, etc.)……..		
Latex rubber……..		
Other (please list) _____		

8. Women only	Yes	No
a) Are you pregnant or think you may be pregnant?.....		
b) Are you nursing?.....		
c) Are you taking any oral contraceptives?.....		

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

	Yes	No		Yes	No		Yes	No
High blood pressure……....			Heart disease……..			Chest pains……....		
Heart attack……..			Cardiac pacemaker……....			Easily winded……		
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…….			Heart trouble……..		
AIDS or HIV Infection……....			Sexually Transmitted Disease.....			Mitral Valve Prolapse……		
Thyroid problem……..			Stomach trouble/Ulcers……....			Other……..		

Patient Dental History

Name of Previous Dentist and Location _____ **Date of last exam** _____

	Yes	No
1. Do you 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 every 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 ever 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?.....		

Authorization and Release

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