

PATIENT NAME _____

HOME ADDRESS _____

TODAY'S DATE _____

DATE OF BIRTH _____

BUSINESS ADDRESS _____

HOME PHONE _____

BUSINESS PHONE _____

SOC. SEC. NO. _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____

OFFICE PHONE _____

DATE OF LAST EXAM _____

YES NO

1. Are you under medical treatment now?

7. Are you allergic to or have you had any reactions to the following?

2. Have you ever been hospitalized for any surgical operation or serious illness?

YES NO Local anesthetics (eg. novocaine) YES NO Barbiturates YES NO Aspirin

3. Are you taking any medication(s) including non-prescription medicine?

YES NO Penicillin or other antibiotics YES NO Sedatives YES NO Other

If yes, what medication(s) are you taking? _____

YES NO Sulfa Drugs YES NO Iodine

4. Do you use tobacco? ..

8. WOMEN ONLY: YES NO

5. Do you use alcohol, cocaine or other drugs?

 a) Are you pregnant or think you may be pregnant?

6. Are you wearing contact lenses?

 b) Are you nursing? c) Are you taking birth control pills?

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

YES NO

High Blood Pressure
 Heart Attack
 Rheumatic Fever
 Swollen Ankles
 Fainting / Seizures
 Asthma
 Low Blood Pressure
 Epilepsy / Convulsions
 Leukemia
 Diabetes
 Kidney Diseases
 AIDS or HIV Infection
 Thyroid Problem

YES NO

Heart Disease
 Cardiac Pacemaker
 Heart Murmur
 Angina
 Frequently Tired
 Anemia
 Emphysema
 Cancer
 Arthritis
 Joint Replacement or Implant
 Hepatitis / Jaundice
 Sexually Transmitted Disease
 Stomach Troubles / Ulcers

YES NO

Chest Pains
 Easily Winded
 Stroke
 Hay Fever / Allergies
 Tuberculosis
 Radiation Therapy
 Glaucoma
 Recent Weight Loss
 Liver Disease
 Heart Trouble
 Respiratory Problems
 Other _____

COMMENTS

Signature of Dentist

Date

PATIENT DENTAL HISTORY

YES NO

YES NO

1. Do your gums bleed while brushing or flossing? 8. Do you have frequent headaches?
 2. Are your teeth sensitive to hot or cold liquids/foods? 9. Do you clench or grind your teeth?
 3. Are your teeth sensitive to sweet or sour liquids/foods? 10. Do you bite your lips or cheeks frequently?
 4. Do you feel pain to any of your teeth? 11. Have you ever had any difficult extractions in the past?
 5. Do you have any sores or lumps in or near your mouth? 12. Have you had any orthodontic work?
 6. Have you had any head, neck or jaw injuries? 13. Have you ever had prolonged bleeding following extractions?
 7. Have you ever experienced any of the following problems in your jaw?
 a) Clicking? 14. Have you ever had instruction on the correct method of brushing your teeth?
 b) Pain (joint, ear, side of face)? 15. Have you ever had instructions on the care of your gums?

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