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?	☐	☐

IF YES, PLEASE EXPLAIN ________________

____

	YES	NO
3. ARE YOU TAKING ANY MEDICATION (S), INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐

PLEASE LIST ________________________

____

	YES	NO
4. HAVE YOU TAKEN PHEN-PEN OR REDUX?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

☐ LOCAL ANESTHETICS ☐ BARBITURATES ☐ ASPIRIN

☐PENICILLIN ☐SEDATIVES ☐SULFA DRUGS ☐IODINE

☐LATEX ☐OTHER ________________

8. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? YES ☐ NO ☐

9. **WOMEN ONLY**

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

10. DO YOU HAVE ANY OF THE FOLLOWING?

☐ HIGH BLOOD PRESSURE
☐ LOW BLOOD PRESSURE
☐ HEART ATTACK
☐ RHEUMATIC FEVER
☐ MITRAL VALVE PROLAPSE
☐ HEART DISEASE
☐ HEART MURMUR
☐ CARDIAC PACEMAKER
☐ DIABETES
☐ EPILEPSY/ CONVULSIONS
☐ FAINTING/ SEIZURES
☐ ASTHMA
☐ KIDNEY DISEASE
☐ THYROID DISEASE
☐ ANEMIA
☐ CHEST PAINS
☐ EMPHYSEMA
☐ CANCER
☐ ARTHRITIS
☐ JOINT REPLACEMENT OR IMPLANT
☐ HEPATITIS TYPE ________
☐ PSYCHIATRIC CARE
☐ STOMACH TROUBLE/ ULCERS
☐ STROKE
☐ ALLERGIES
☐ TUBERCULOSIS
☐ AIDS OR HIV INFECTION
☐ SEXUALLY TRANSMITTED DISEASE
☐ RADIATION THERAPY OR CHEMO
☐ GLAUCOMA
☐ RECENT WEIGHT LOSS
☐ LIVER DISEASE
☐ RESPIRATORY PROBLEMS
☐ DIZZINESS
☐ OTHER ________________

____

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEETS?	☐	☐
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	☐	☐
7. HAVE YOU HAD A FULL MOUTH X-RAY TAKEN?	☐	☐

WHEN AND WHERE ________________________

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
11. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
12. HAVE YOU EVER HAD INSTRUCTIONS ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
13. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐
14. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE?	☐	☐
15. HAVE YOU EVER USED NITROUS OXIDE DURING DENTAL TREATMENTS? DO YOU WANT TO USE IT IN THIS OFFICE?	☐	☐
16. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐

Release:
I authorize the dentist to perform diagnostic procedures & treatment as may be necessary for proper dental care. I authorize release of any information concerning my or my child's health care, advice & treatment provided for the purpose of evaluating & administering claims for insurance benefits or to another dentist. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that, where appropriate, credit bureau reports may be obtained. I attest to the accuracy of the information on these pages.

Signature of patient ____ **Date** ________________