

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. Have you ever taken Phen-Fen/Redux? ☐ ☐

5. Do you use tobacco? ☐ ☐

6. Do you use controlled substances? ☐ ☐

7. Are you wearing contact lenses? ☐ ☐

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

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>

9. Are you allergic to or have you had any reactions to the following:

Local Anesthetics (eg. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals (eg. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

10. Women Only:

Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

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	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>

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? ☐ ☐

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance

company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent if minor)

MEDICAL HISTORY UPDATE			
DATE	COMMENTS	DATE	COMMENTS
DATE	COMMENTS	DATE	COMMENTS
DATE	COMMENTS	DATE	COMMENTS