Patient Medical History

Patient's Name _____ Physican's Name _____

	YES	NO
1. Are you under treatment now?	☐	☐
For what: _____		
2. Have you ever been hospitalized for any surgical operation or serious illness within the last five 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 allergic to or have you had any reactions to the following?	YES	NO
Local Anesthetics (eg. xylocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Asprin	☐	☐
Any Metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐
_____		
7. Women Only:		
a) Are you pregnant or think you may be pregnant ?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

	YES	NO		YES	NO		YES	NO
Heart Disease	☐	☐	Emphysema	☐	☐	Fainting/Seizures	☐	☐
Heart Attack	☐	☐	Hay Fever/Allergies	☐	☐	Epilepsy/Convulsions	☐	☐
Heart Murmur	☐	☐	AIDS or HIV Infection.	☐	☐	Diabetes	☐	☐
Rheumatic Fever	☐	☐	Sexually Transmitted Disease	☐	☐	Kidney Disease	☐	☐
Cardiac Pacemaker	☐	☐	Cancer	☐	☐	Thyroid Problem	☐	☐
Mitral Valve Prolapse	☐	☐	Leukemia	☐	☐	Anemia	☐	☐
High Blood Pressure	☐	☐	Radiation Therapy	☐	☐	Arthritis	☐	☐
Low Blood Pressure.	☐	☐	Recent Weight Loss	☐	☐	Stomach Troubles/Ulcers	☐	☐
Swollen Ankles	☐	☐	Joint Replacement or Implant	☐	☐	Alcoholism	☐	☐
Angina	☐	☐	Liver Disease.	☐	☐	Stroke	☐	☐
Respiratory Problems	☐	☐	Hepatitis	☐	☐	Glaucoma	☐	☐
Asthma	☐	☐	Type: _____			Other	☐	☐
Tuberculosis	☐	☐	Date: _____			_____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	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 sweets?	☐	☐
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	☐	☐
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 had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. 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 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.

_____

Signature of patient (or parent if minor) Date