PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

EMPLOYER _____ BUSINESS PHONE _____

INSURANCE CO. _____ SS#/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under any medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking? _____		
4. Do you smoke or use smokeless tobacco?	❑	❑
5. Have you ever been addicted to a controlled substance?	❑	❑
6. Are you wearing contact lenses?	❑	❑

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

YES	NO		YES	NO		YES	NO	
❑	❑	Local anesthetics (eg. novocaine)	❑	❑	Barbiturates	❑	❑	Aspirin
❑	❑	Penicillin	❑	❑	Sedatives	❑	❑	Other
❑	❑	Other Antibiotics						_____
❑	❑	Sulfa Drugs	❑	❑	Iodine			_____

8. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
b) Are you taking birth control pills?	❑	❑

9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ❑ ❑

10. 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
❑	❑	Epilepsy / Convulsions	❑	❑	Emphysema	❑	❑	Glaucoma
❑	❑	Leukemia	❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Diabetes	❑	❑	Arthritis	❑	❑	Liver Disease
❑	❑	Kidney Diseases	❑	❑	Joint Replacement or Implant	❑	❑	Mitral Valve Prolapse
❑	❑	AIDS or HIV Infection	❑	❑	Hepatitis / Jaundice	❑	❑	Respiratory Problems
❑	❑	Thyroid Problem	❑	❑	Sexually Transmitted Disease	❑	❑	Mental Disorders
❑	❑	Other	❑	❑	Stomach Troubles / Ulcers	❑	❑	Other _____

COMMENTS

_____

_____

_____

_____

_____

_____

Signature of Dentist Date

PATIENT DENTAL HISTORY

	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?		
a) Clicking?	❑	❑
b) Pain (joint, ear, side of face)?	❑	❑
c) Difficulty in opening or closing?	❑	❑
d) 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 had any orthodontic treatment?	❑	❑
13. Have you ever had prolonged bleeding following extractions:	❑	❑
14. Have you ever had instruction on the correct method of brushing your teeth?	❑	❑
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