

# PATIENT MEDICAL HISTORY

Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

YES NO

YES NO

1. Are you under medical treatment now?  YES  NO
2. Have you ever been hospitalized for any surgical operations or serious illness?  YES  NO
3. Are you taking any medication(s) including non-prescription medicine?  YES  NO  
If YES what medications are you taking? \_\_\_\_\_
4. Do you use tobacco?  YES  NO
5. Do you use alcohol, cocaine, other drugs?  YES  NO
6. Are you wearing contact lenses?  YES  NO
7. Have you ever been pre-medicated with antibiotics for your dental treatment?  YES  NO
8. Are you allergic to or have you had any reactions to the following? e.g. \_\_\_\_\_

- Local Anesthetics (e.g. novocaine)  YES  NO
- Penicillin or other Antibiotics  YES  NO
- Sulfa Drugs  YES  NO
- Barbiturates  YES  NO
- Sedatives  YES  NO
- Iodine  YES  NO
- Aspirin  YES  NO
- Other \_\_\_\_\_

9. Women only:
- a) Are you pregnant or do you think you may be pregnant?  YES  NO
- b) Are you nursing?  YES  NO
- c) Are you taking birth control pills?  YES  NO

## 10. Do you have or have you had any of the following?

YES NO

YES NO

YES NO

- |                       |                          |                          |                      |                          |                          |               |                          |                          |
|-----------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|
| High Blood Pressure   | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Disease      | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers        | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack          | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur         | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains   | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever       | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies  | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles        | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired     | <input type="checkbox"/> | <input type="checkbox"/> | Stroke        | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures     | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss   | <input type="checkbox"/> | <input type="checkbox"/> | Angina        | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema            | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis  | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure    | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy    | <input type="checkbox"/> | <input type="checkbox"/> | Cancer        | <input type="checkbox"/> | <input type="checkbox"/> |
| STD                   | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma      | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia              | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement    | <input type="checkbox"/> | <input type="checkbox"/> | Anemia        | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes              | <input type="checkbox"/> | <input type="checkbox"/> | Joint Implant        | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidneys               | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice   | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Other _____   |                          |                          |
| Thyroid Problem       | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Trouble      | <input type="checkbox"/> | <input type="checkbox"/> |               |                          |                          |
| Heart Disease         | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |               |                          |                          |

# PATIENT DENTAL HISTORY

YES NO

YES NO

1. Do your gums bleed while brushing or flossing?  YES  NO
2. Are your teeth sensitive to hot or cold liquids and/or foods?  YES  NO
3. Are your teeth sensitive to sweet or sour liquids and or foods?  YES  NO
4. Do you feel any pain in your teeth?  YES  NO
5. Do you have any head neck or jaw injuries?  YES  NO
6. Have you ever experienced any of the following problems in your jaw:
  - a) Clicking?  YES  NO
  - b) Pain (joint, ear side of face)?  YES  NO
  - c) Difficulty in opening or closing?  YES  NO
  - d) Difficulty in chewing?  YES  NO
7. Do you clench or grind your teeth?  YES  NO
8. Do you have frequent headaches?  YES  NO
9. Do you bite your lips or cheeks frequently?  YES  NO
10. Have you ever had any difficult extractions in the past?  YES  NO
11. Have you had any orthodontic work?  YES  NO
12. Have you ever had any prolonged bleeding following extractions of your teeth?  YES  NO
13. Have you ever had instruction on the correct method of brushing your teeth?  YES  NO
14. Have you ever had instruction on the care of your gums ?  YES  NO
15. Date of last dental check-up: \_\_\_\_\_

# 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 child's health I authorize the dentist to release any information including the diagnostic and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers 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.

Signature of parent/guardian if patient is minor: \_\_\_\_\_ Date: \_\_\_\_\_