Patient Medical History

Physician: _____ Office Phone: _____ Last Exam: _____

Are you under medical treatment now? N Y

Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years? N Y

If yes, please explain: _____

List Medications you are currently taking: _____

_____

Do you use tobacco? N Y

Are you allergic to or have you had any reactions to any of the following? Please circle below:

Local Anesthetics (e.g. Novocain) Penicillin or any other Antibiotics Other: _____

Sulfa Drugs Any Metals (e.g. Nickel, Mercury, etc.) Latex Rubber

Do you have any of the following?

AIDS/HIV Infection	N Y	Frequently Tired	N Y	Mitral Valve Prolapse	N Y
Angina	N Y	Glaucoma	N Y	Radiation Therapy	N Y
Arthritis	N Y	Hay Fever/Allergies	N Y	Recent Weight Loss	N Y
Asthma	N Y	Heart Attack	N Y	Respiratory Problems	N Y
Autism Spectrum	N Y	Heart Disease	N Y	Rheumatic Fever	N Y
Cancer _____	N Y	Heart Murmur	N Y	Stroke	N Y
Cardiac Pacemaker	N Y	Hepatitis/Jaundice	N Y	Swollen Ankles	N Y
Chest Pains	N Y	High Blood Pressure	N Y	Tuberculosis	N Y
Diabetes	N Y	Joint Replaced/Implant	N Y	Ulcers	N Y
Easily Winded	N Y	Kidney Disease	N Y	Other: _____	
Emphysema	N Y	Leukemia	N Y	Other: _____	
Epilepsy/Convulsions	N Y	Liver Disease	N Y	Other: _____	
Fainting/Seizures	N Y	Low Blood Pressure	N Y	Other: _____	

Women Only:	Are you pregnant or think you may be pregnant? N Y	Are you nursing?	N Y
		Are you taking oral contraceptives?	N Y

Patient Dental History

Previous Dentist/Location _____ Last Visit _____

Do your gums bleed while brushing or flossing?	N Y	Do you have frequent headaches?	N Y
Are your teeth sensitive to hot/cold liquids/food?	N Y	Do you clench or grind your teeth?	N Y
Are your teeth sensitive to sweet/sour liquids/food?	N Y	Do you bite your lips/cheeks frequently?	N Y
Do you feel pain to any of your teeth?	N Y	Have you ever had any difficult extractions?	N Y
Do you have any sores/lumps in or near your mouth?	N Y	Have you had any prolonged bleeding after an extraction?	N Y
Have you had any head/neck/jaw injuries?	N Y	Have you had any orthodontic treatment?	N Y
		Do you wear dentures/partials?	N Y
		If yes, date of placement _____	
Have you ever experienced any of the following?		Have you ever had oral hygiene instructions regarding the care of your teeth?	N Y
Circle: Clicking		Do you like your smile?	N Y
Pain (joint, ear, side of face)			
Difficulty in opening or closing			
Difficulty in chewing			

Patient Name: _____ X _____ Date: _____

Please print Signature of patient (or parent/guardian)