



MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Do you have any known allergies? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other If yes, please explain:

Do you have, or have you had, any of the following?

- AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT; or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Douglas A. Wheelock, DDS, PC  
Brian B. Bursick, DDS and Laura E. Giese, DDS

**NEW PATIENT QUESTIONNAIRE**

Patient Name \_\_\_\_\_

Did you hear about our office from a Friend?    Yes            No

If yes, who can we thank for inviting you to our office? \_\_\_\_\_

If you didn't hear about our office from a friend, how did you hear about our office? (Please circle one)

Phone Book

Television

Radio

Newspaper

Location

Other: \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Chief Dental  
Complaint \_\_\_\_\_

Have you had any dental treatment recommended that was not completed? \_\_\_\_\_

What did you like most about any dentist that you have seen? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

How long since your last dental visit? \_\_\_\_\_

What was the nature of your last visit? \_\_\_\_\_

Have you had any serious trouble associated with any previous dental treatment? \_\_\_\_\_

What did you like least about any dentist you have seen? \_\_\_\_\_

If you could wave a magic wand and change one thing about your smile, what would it be? \_\_\_\_\_

Are you interested in whitening your teeth? \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_