

## PATIENT MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

PHYSICIAN'S Name \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

**Yes No**

- Are you under a physician's care now?   If yes, explain \_\_\_\_\_
- Have you been hospitalized or had a major operation?   If yes, explain \_\_\_\_\_
- Are you taking medications, including non-prescription?   If yes, explain \_\_\_\_\_
- Do you, or have you taken Fen-Phen or Redux?   If yes, explain \_\_\_\_\_
- Are you on a special diet?   If yes, explain \_\_\_\_\_
- Have you had any metal rods, pins, or implants?   If yes, explain \_\_\_\_\_
- Do you smoke or use tobacco in any form?
- Do you use controlled substances?

### DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

**Yes No**

**Yes No**

**Yes No**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV positive<br><input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease<br><input type="checkbox"/> <input type="checkbox"/> Anemia<br><input type="checkbox"/> <input type="checkbox"/> Angina, Chest Pains<br><input type="checkbox"/> <input type="checkbox"/> Arthritis/Gout<br><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve<br><input type="checkbox"/> <input type="checkbox"/> Artificial Joint<br><input type="checkbox"/> <input type="checkbox"/> Asthma<br><input type="checkbox"/> <input type="checkbox"/> Blood Disease<br><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion<br><input type="checkbox"/> <input type="checkbox"/> Breathing Problem<br><input type="checkbox"/> <input type="checkbox"/> Bruise Easily<br><input type="checkbox"/> <input type="checkbox"/> Cancer<br><input type="checkbox"/> <input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disorder<br><input type="checkbox"/> <input type="checkbox"/> Convulsions<br><input type="checkbox"/> <input type="checkbox"/> Diabetes<br><input type="checkbox"/> <input type="checkbox"/> Drug Addiction<br><input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding<br><input type="checkbox"/> <input type="checkbox"/> Easily Winded<br><input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures<br><input type="checkbox"/> <input type="checkbox"/> Excessive Thirst<br><input type="checkbox"/> <input type="checkbox"/> Fainting Spells/Dizziness<br><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches<br><input type="checkbox"/> <input type="checkbox"/> Glaucoma<br><input type="checkbox"/> <input type="checkbox"/> Hay Fever<br><input type="checkbox"/> <input type="checkbox"/> Heart Attack/Failure<br><input type="checkbox"/> <input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> <input type="checkbox"/> Heart Pace Maker<br><input type="checkbox"/> <input type="checkbox"/> Heart Trouble/Disease<br><input type="checkbox"/> <input type="checkbox"/> Hemophilia<br><input type="checkbox"/> <input type="checkbox"/> Hepatitis A<br><input type="checkbox"/> <input type="checkbox"/> Hepatitis B or C<br><input type="checkbox"/> <input type="checkbox"/> Herpes<br><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> <input type="checkbox"/> Hives or Rash<br><input type="checkbox"/> <input type="checkbox"/> Hypoglycemia<br><input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat<br><input type="checkbox"/> <input type="checkbox"/> Kidney Problems<br><input type="checkbox"/> <input type="checkbox"/> Leukemia<br><input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure<br><input type="checkbox"/> <input type="checkbox"/> Lung Disease<br><input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse<br><input type="checkbox"/> <input type="checkbox"/> Parathyroid Disease<br><input type="checkbox"/> <input type="checkbox"/> Psychiatric Care<br><input type="checkbox"/> <input type="checkbox"/> Radiation Treatments<br><input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss<br><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> <input type="checkbox"/> Rheumatism<br><input type="checkbox"/> <input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease<br><input type="checkbox"/> <input type="checkbox"/> Shingles<br><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease<br><input type="checkbox"/> <input type="checkbox"/> Stomach/Intestinal Disease<br><input type="checkbox"/> <input type="checkbox"/> Stroke<br><input type="checkbox"/> <input type="checkbox"/> Swelling of Limbs<br><input type="checkbox"/> <input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> <input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> <input type="checkbox"/> Tumors or Growths<br><input type="checkbox"/> <input type="checkbox"/> Ulcers<br><input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice |
|---|---|---|

Have you ever had any serious illness not listed above? (describe) \_\_\_\_\_

### WOMEN ONLY

**Yes No**

- Are you pregnant or possibly pregnant Due Date \_\_\_\_\_
- Are you nursing
- Are you taking oral contraceptives

**(CONTINUED ON OTHER SIDE) →**

## ALLERGIES

### DO YOU HAVE ANY OF THE FOLLOWING ALLERGIES?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin, any antibiotic	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics (novocaine, lidocaine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Codeine, other pain medication	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	Latex sensitivity, contact dermatitis			
<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to any other medication _____			

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## PATIENT DENTAL HISTORY

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Why have you come to our practice today? \_\_\_\_\_

How nervous does dental treatment make you?  Not at all  Slightly  Moderately  Extremely

### PLEASE ANSWER THE FOLLOWING:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed while brushing or flossing	<input type="checkbox"/>	<input type="checkbox"/>	Clicking, popping, or grinding	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Pain in jaw	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing
<input type="checkbox"/>	<input type="checkbox"/>	Tooth or mouth pain recently	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to cold
<input type="checkbox"/>	<input type="checkbox"/>	Have any sores / lumps in or near your mouth	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to hot
<input type="checkbox"/>	<input type="checkbox"/>	Any mouth, head, neck or jaw injuries	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn partials / dentures	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to sweets
<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment / braces	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity when biting
<input type="checkbox"/>	<input type="checkbox"/>	Unpleasant taste / bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Any oral surgery procedures			
<input type="checkbox"/>	<input type="checkbox"/>	Periodontal / gum surgery or disease	<input type="checkbox"/>	<input type="checkbox"/>	Require Antibiotic before dental treatment			
<input type="checkbox"/>	<input type="checkbox"/>	Any unpleasant dental experience? If yes, describe _____						
<input type="checkbox"/>	<input type="checkbox"/>	Any complications with / reaction to dental treatment? If yes, describe _____						
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any dental concerns? If yes, describe _____						

How many times do you Brush per day? \_\_\_\_\_ How many times do you Floss per week? \_\_\_\_\_

What do you like about your teeth? \_\_\_\_\_

What do you dislike about your teeth? \_\_\_\_\_

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 or dental status.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date