

PATIENT NAME _____
HOME ADDRESS _____
E-MAIL ADDRESS _____
BUSINESS ADDRESS _____

TODAY'S DATE _____
DATE OF BIRTH _____
HOME PHONE _____
CELL PHONE _____
BUSINESS PHONE _____
SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

1. Are you under medical treatment now? YES NO
2. Have you ever been hospitalized for any surgical operation or serious illness? YES NO
3. Are you taking any medication(s) including non-prescription medicine? YES NO
4. Have you ever taken Fen-Phen/Redux? YES NO
5. Do you use tobacco? YES NO
6. Do you use alcohol, cocaine or other drugs? YES NO
7. Are you wearing contact lenses? YES NO
8. Are you allergic to or have you had any reactions to the following? YES NO
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? YES NO
10. WOMEN ONLY: a) Are you pregnant or think you may be pregnant? b) Are you nursing? c) Are you taking birth control pills?

11. 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
Low Blood Pressure Emphysema Glaucoma
Epilepsy / Convulsions Cancer Recent Weight Loss
Leukemia Arthritis Liver Disease
Diabetes Joint Replacement or Implant Heart Trouble
Kidney Disease Hepatitis / Jaundice Respiratory Problems
AIDS or HIV Infection Sexually Transmitted Disease Other
Thyroid Problem Stomach Troubles / Ulcers

COMMENTS
Signature of Dentist _____ Date _____

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing? YES NO
2. Are your teeth sensitive to hot or cold liquids/foods? YES NO
3. Are your teeth sensitive to sweet or sour liquids/foods? YES NO
4. Do you feel pain to any of your teeth? YES NO
5. Do you have any sores or lumps in or near your mouth? YES NO
6. Have you had any head, neck or jaw injuries? YES NO
7. Have you ever experienced any of the following problems in your jaw? YES NO
8. Do you have frequent headaches? YES NO
9. Do you clench or grind your teeth? YES NO
10. Do you bite your lips or cheeks frequently? YES NO
11. Have you ever had any difficult extractions in the past? YES NO
12. Have you had any orthodontic work? YES NO
13. Have you ever had prolonged bleeding following extractions? YES NO
14. Have you ever had instruction on the correct method of brushing your teeth? YES NO
15. Have you ever had instructions on the care of your gums? YES NO

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