

PATIENT NAME _____ SOC. SEC.# _____ DATE _____
 ADDRESS _____ DATE OF BIRTH _____ PRIMARY PHONE _____
 CITY/ZIP _____ EMPLOYER _____ SECONDARY PHONE _____
 EMAIL _____ WORK PHONE _____
 PARENT or SPOUSE _____ PRIMARY PHONE _____
 RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____
 DENTAL INSURANCE CARRIER _____
 WHOM MAY WE THANK FOR REFERRING YOU _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

- | | | | | | |
|---|--------------------------|--------------------------|--|--|---|
| | YES | NO | | | |
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you allergic to or have you had any reactions to the following? | | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> | <input type="checkbox"/> | YES NO | YES NO | YES NO |
| 3. Are you taking any medication(s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Local anesthetics (eg. novocaine) | <input type="checkbox"/> <input type="checkbox"/> Barbiturates | <input type="checkbox"/> <input type="checkbox"/> Aspirin |
| If yes, what medication(s) are you taking? _____ | | | <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> <input type="checkbox"/> Sedatives | <input type="checkbox"/> <input type="checkbox"/> Latex |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> <input type="checkbox"/> Iodine | Other _____ |
| 5. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | 10. WOMEN ONLY: | | YES NO |
| 6. Do you use alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use other drugs? | <input type="checkbox"/> | <input type="checkbox"/> | b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | c) Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have or have you had any of the following? | | | 11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |

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|---|--|---|
| YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Hay Fever / Allergies |
| <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Fainting / Seizures | <input type="checkbox"/> <input type="checkbox"/> Angina | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> Leukemia | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement or Implant | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles / Ulcers | <input type="checkbox"/> <input type="checkbox"/> _____ |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> <input type="checkbox"/> Chest Pains | |

COMMENTS (For Dr. Use Only)

Signature of Dentist _____ Date _____

PATIENT DENTAL HISTORY

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | YES | NO | | | |
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever experienced any problems in your jaw? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 7. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 8. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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** _____ **DATE** _____
 PATIENT, PARENT OR GUARDIAN