Patient Medical & Dental History

Patient's Last Name	Patient's First Name	Today's Date

Medical History

Physician	Office Phone Number	Date of Last Exam
	( )	/ /

Are you under medical treatment now? □ Yes □ No

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? □ Yes □ No

If yes, please explain: ___________________________________

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Are you taking any medication(s) including non-prescription medicine? □ Yes □ No

If yes, what medications?: _______________________________

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Have you ever taken Phen-Fen/Redux? □ Yes □ No

Do you use tobacco? □ Yes □ No

Do you use controlled substances? □ Yes □ No

Do you snore? □ Yes □ No

Has anyone ever told you that you quit breathing during your sleep? □ Yes □ No

Are you allergic to or have you had any reactions to the following?

- Local Anesthetics (e.g. Novocain) □ Yes □ No
- Penicillin or other Antibiotics □ Yes □ No
- Sulfa Drugs □ Yes □ No
- Barbiturates □ Yes □ No
- Sedatives □ Yes □ No
- Iodine □ Yes □ No
- Aspirin □ Yes □ No
- Any Metals (e.g. nickel, mercury) □ Yes □ No
- Latex Rubber □ Yes □ No
- Other: ____

Women Only:

- Are you pregnant or think you may be pregnant? □ Yes □ No
- Are you nursing? □ Yes □ No
- Are you taking oral contraceptives? □ Yes □ No

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

Condition		Condition		Condition	
AIDS or HIV	□ Yes □ No	Hay Fever/Allergies	□ Yes □ No	Respiratory Problems	□ Yes □ No
Anemia	□ Yes □ No	Heart Attack	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Angina	□ Yes □ No	Heart Disease	□ Yes □ No	STDs	□ Yes □ No
Arthritis	□ Yes □ No	Heart Murmur	□ Yes □ No	Stomach Ulcers	□ Yes □ No
Asthma	□ Yes □ No	Hepatitis/Jaundice	□ Yes □ No	Stroke	□ Yes □ No
Bleeding Disorder/Clotting	□ Yes □ No	High Blood Pressure	□ Yes □ No	Swollen Ankles	□ Yes □ No
Cancer	□ Yes □ No	Joint Replacement	□ Yes □ No	Thyroid Problems	□ Yes □ No
Cardiac Pacemaker	□ Yes □ No	Kidney Disease	□ Yes □ No	Tuberculosis	□ Yes □ No
Diabetes	□ Yes □ No	Leukemia	□ Yes □ No	Other:__________________________	
Easily Winded	□ Yes □ No	Liver Disease	□ Yes □ No	______________________________	
Emphysema	□ Yes □ No	Low Blood Pressure	□ Yes □ No	______________________________	
Epilepsy/Convulsions	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No		
Fainting/Seizures	□ Yes □ No	Radiation Therapy	□ Yes □ No		
Frequently Tired	□ Yes □ No	Recent Weight Gain	□ Yes □ No		
Glaucoma	□ Yes □ No	Recent Weight Loss	□ Yes □ No		

Dental History

Name of Previous Dentist	Location of Previous Dentist	Date of Last Exam
		/ /

Do you suffer from any dental anxieties?

Do your gums bleed when brushing/flossing? □ Yes □ No
Are your teeth sensitive to hot and cold? □ Yes □ No
Are your teeth sensitive to sweet or sour? □ Yes □ No
Do you feel pain to any of your teeth? □ Yes □ No
Do you have any sores or lumps near your mouth? □ Yes □ No
Have you had any head, neck or jaw injuries? □ Yes □ No
Have you ever experienced any of the following problems in your jaw?

- Clicking □ Yes □ No
- Pain □ Yes □ No
- Difficulty opening or closing □ Yes □ No
- Difficulty chewing □ Yes □ No

Do you have frequent headaches? □ Yes □ No
Do you clench or grind your teeth? □ Yes □ No
Do you bite your lips or cheeks? □ Yes □ No
Have you had difficult extractions in the past? □ Yes □ No
Have you had any prolonged bleeding following extractions? □ Yes □ No
Have you had orthodontic treatment? □ Yes □ No
Do you wear dentures or partials? □ Yes □ No
If yes, date of placement: ______________________________
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? □ Yes □ No
Do you like your smile? □ Yes □ No

Authorization and Release

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. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. It is my responsibility to inform the dental office of any changes with my medical status.

____ ______________

Signature of Patient or Parent Date

Patient's Initials/Witness/Date	Patient's Initials/Witness/Date	Patient's Initials/Witness/Date	Patient's Initials/Witness/Date