PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

EMAIL _____ CELL PHONE _____

EMPLOYER _____ BUSINESS PHONE _____

INSURANCE CO. _____ SS#/SIN _____

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

		YES	NO
1.	Are you under medical treatment now? If so, what: _____	❑	❑
2.	Have you been hospitalized for any surgical operation or serious illness? If so, what: _____	❑	❑
3.	Are you taking any medication(s) including non-prescription medicine? If yes, what medications are you taking? _____	❑	❑
4.	Do you use tobacco?	❑	❑
5.	Do you use alcohol?	❑	❑
6.	Do you use cocaine or other drugs?	❑	❑
7.	Are you wearing contact lenses?	❑	❑

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

YES	NO		YES	NO		YES	NO	
❑	❑	Local Anesthetics (e.g. Novocaine)	❑	❑	Barbiturates	❑	❑	Aspirin
❑	❑	Penicillin or other antibiotics	❑	❑	Sedatives	❑	❑	Other
❑	❑	Sulfa Drugs	❑	❑	Iodine			

		YES	NO
9.	WOMEN ONLY:		
	a.) Are you pregnant or think you may be pregnant?	❑	❑
	b.) Are you nursing?	❑	❑
	c.) Are you taking birth control pills?	❑	❑
10.	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑	❑

11. Do you have 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/High Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma
❑	❑	Epilepsy / Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease
❑	❑	Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble
❑	❑	Kidney Diseases	❑	❑	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

		YES	NO
1.	Do your gums bleed while brushing or flossing?	❑	❑
2.	Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3.	Are your teeth sensititve to sweet or sour liquids/foods?	❑	❑
4.	Do you feel pain to any of your teeth?	❑	❑
5.	Do you have any sores or lumps in or near you mouth?	❑	❑
6.	Have you had any head, neck, or jaw injuries?	❑	❑
7.	Have you ever experienced any of the following problems in your jow?		
	a.) Clicking?	❑	❑
	b.) Pain (joint, ear, side of face)?	❑	❑
	c.) Difficulty opening or closing?	❑	❑
	d.) Difficulty chewing?	❑	❑

		YES	NO
8.	Do you have frequent headaches?	❑	❑
9.	Do you clench or grind you teeth?	❑	❑
10.	Do you bite your lips or cheeks frequently?	❑	❑
11.	Have you ever had any difficult extractions in the past?	❑	❑
12.	Have you ever had any orthodontic treatment?	❑	❑
13.	Have you ever had any prolonged bleeding following extractions?	❑	❑
14.	Have you ever had instruction on the correct method of brushing your teeth?	❑	❑
15.	Have you ever had instructions on the care of your gums?	❑	❑

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