Patient Medical History

Physician: ______________________ Office Phone: ______________ Date of Last Exam: ______________

Question	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yars? If yes, please explain ______________________	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, What medication(s) are you taking? ______________________	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphospho nates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

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

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Kidney Diseases	☐	☐	Cancer	☐	☐	Tuberculosis
☐	☐	Heart Attack	☐	☐	AIDS or HIV Infection	☐	☐	Arthritis	☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever	☐	☐	Thyroid Problem	☐	☐	Joint Replacement or Implant	☐	☐	Glaucoma
☐	☐	Swollen Ankles	☐	☐	Heart Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Recent Weight Loss
☐	☐	Fainting/Seizures	☐	☐	Cardiac Pacemaker	☐	☐	Sexually Transmitted Disease	☐	☐	Liver Disease
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Stomach Troubles/Ulcers	☐	☐	Heart Trouble
☐	☐	Low Blood Pressure	☐	☐	Angina	☐	☐	Chest Pains	☐	☐	Respiratory Problems
☐	☐	Epilepsy/Convulsions	☐	☐	Frequently Tired	☐	☐	Easily Winded	☐	☐	Mitral Valve Prolapse
☐	☐	Leukemia	☐	☐	Anemia	☐	☐	Stroke	☐	☐	Hemophilia/bleeding disorders
☐	☐	Diabetes	☐	☐	Emphysema	☐	☐	Hay Fever/Allergies			Other: ______________

Question	Yes	No
10. Are you wearing contacts?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________________		
12. Do you have a persistent cough or throat clearing not associated with a known illness? (Lasting more than 3 weeks)	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________

Question	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 sensitive 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 your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your 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 prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatments?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Family History

Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Bleeding Disorders

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 authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments ____

____

______________________ Signature ______________________ Date ______________