

Patient \_\_\_\_\_ SSN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex: \_\_\_ M \_\_\_ F Birthdate \_\_\_\_\_ Home # \_\_\_\_\_  
 Employed By \_\_\_\_\_ Work # \_\_\_\_\_

**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"/> | 7. 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"/> Other _____ |
| 4. Do you use tobacco?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs                       | <input type="checkbox"/> <input type="checkbox"/> Iodine       |   |
| 5. Do you use alcohol, cocaine or other drugs?                                    | <input type="checkbox"/> | <input type="checkbox"/> | 8. WOMEN ONLY:  |  | YES NO  |
| 6. Are you wearing contact lenses?  | <input type="checkbox"/> | <input type="checkbox"/> | a) Are you pregnant or think you may be pregnant?                                   | <input type="checkbox"/>                                       | <input type="checkbox"/>                                      |
|   |                          |                          | b) Are you nursing?   | <input type="checkbox"/>                                       | <input type="checkbox"/>                                      |
|   |                          |                          | c) Are you taking birth control pills?  | <input type="checkbox"/>                                       | <input type="checkbox"/>                                      |

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

**COMMENTS**

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Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT DENTAL HISTORY**

- |   |                          |                          |   |                          |                          |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
|   | YES                      | NO                       |   | YES                      | NO                       |
| 1. Do your gums bleed while brushing or flossing?                       | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?               | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?             | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?                               | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past?                    | <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"/> | 12. Have you had any orthodontic work?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?                         | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had prolonged bleeding following extractions?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? |                          |                          | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Clicking?  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had instructions on the care of your gums?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)?                                     | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| c) Difficulty in opening or closing?                                    | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| d) Difficulty in chewing?   | <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 \_\_\_\_\_