Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Please circle appropriate response. (YES or NO)

Are you under a physician's care now?	YES	NO	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	YES	NO	If yes, please explain: _____
Have you ever had a serious head or neck injury?	YES	NO	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	YES	NO	If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux?	YES	NO	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	YES	NO	
Are you on a special diet?	YES	NO	
Do you use tobacco?	YES	NO	
Do you use controlled substances?	YES	NO	
Do you wear contact lenses?	YES	NO	

Women: Are you… (circle YES or NO)

Pregnant / trying to get pregnant? ☐ Yes ☐ No taking oral contraceptive? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ aspirin ☐ penicillin ☐ codeine ☐ local anesthetics ☐ acrylic ☐ metal

☐ latex ☐ sulfa drugs ☐ other If other, please explain: _____

Do you have or have you ever had any of the following? (circle YES or NO)

AIDS/HIV Positive	YES	NO	Cortisone Medicine	YES	NO	Hemophilia	YES	NO	Radiation Treatments	YES	NO
Alzheimer's Disease	YES	NO	Diabetes	YES	NO	Hepatitis A	YES	NO	Recent Weight Loss	YES	NO
Anaphylaxis	YES	NO	Drug Addiction	YES	NO	Hepatitis B or C	YES	NO	Renal Dialysis	YES	NO
Anemia	YES	NO	Easily Winded	YES	NO	Herpes	YES	NO	Rheumatic Fever	YES	NO
Angina	YES	NO	Emphysema	YES	NO	High Blood Pressure	YES	NO	Rheumatism	YES	NO
Arthritis/Gout	YES	NO	Epilepsy or Seizures	YES	NO	High Cholesterol	YES	NO	Scarlet Fever	YES	NO
Artificial Heart Valve	YES	NO	Excessive Bleeding	YES	NO	Hives or Rash	YES	NO	Shingles	YES	NO
Artificial joint	YES	NO	Excessive Thirst	YES	NO	Hypoglycemia	YES	NO	Sickle Cell Disease	YES	NO
Asthma	YES	NO	Fainting Spells/Dizziness	YES	NO	Irregular Heartbeat	YES	NO	Sinus Trouble	YES	NO
Blood Disease	YES	NO	Frequent Cough	YES	NO	Kidney Problems	YES	NO	Spina Bifida	YES	NO
Blood Transfusion	YES	NO	Frequent Diarrhea	YES	NO	Leukemia	YES	NO	Stomach/Intestinal Disease	YES	NO
Breathing Problem	YES	NO	Frequent Headaches	YES	NO	Liver Disease	YES	NO	Stroke	YES	NO
Bruise Easily	YES	NO	Genital Herpes	YES	NO	Low Blood Pressure	YES	NO	Swelling of Limbs	YES	NO
Cancer	YES	NO	Glaucoma	YES	NO	Lung Disease	YES	NO	Thyroid Disease	YES	NO
Chemotherapy	YES	NO	Hay Fever	YES	NO	Mitral Valve Prolapse	YES	NO	Tonsillitis	YES	NO
Chest Pains	YES	NO	Heart Attack/Failure	YES	NO	Osteoporosis	YES	NO	Tuberculosis	YES	NO
Cold Sores/Fever Blisters	YES	NO	Heart Murmur	YES	NO	Pain in Jaw Joints	YES	NO	Tumors or Growths	YES	NO
Congenital Heart Disorder	YES	NO	Heart Pacemaker	YES	NO	Parathyroid Disease	YES	NO	Ulcers	YES	NO
Convulsions	YES	NO	Heart Trouble/Disease	YES	NO	Psychiatric Care	YES	NO	Venereal Disease	YES	NO
									Yellow Jaundice	YES	NO

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

Do your gums bleed while brushing or flossing?	YES	NO	Difficulty in chewing?	YES	NO
Are your teeth sensitive to hot or cold liquids/foods?	YES	NO	Do you have frequent headaches?	YES	NO
Are your teeth sensitive to sweet or sour liquids/foods?	YES	NO	Do you clench or grind your teeth?	YES	NO
Do you feel pain in any of your teeth?	YES	NO	Do you bite your lips or cheeks frequently?	YES	NO
Do you have any sores or lumps in or near your mouth?	YES	NO	Have you ever had any extractions in the past?	YES	NO
Have you had any head, neck, or jaw injuries?	YES	NO	Have you had any orthodontic treatment?	YES	NO
Have you ever experienced any of the following problems in your jaw:			Do you wear dentures or partials?	YES	NO
Clicking?	YES	NO	If yes, date of placement: _____		
Pain? (joint, ear, side of face)	YES	NO	Have you ever received oral hygiene instructions regarding your teeth and gums?	YES	NO
Difficulty in opening or closing?	YES	NO	Do you like your smile?	YES	NO

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GAURDIAN DATE

_____ _____

SIGNATURE OF DOCTOR DATE

DOCTOR COMMENTS: _____