PATIENT MEDICAL HISTORY

Physician ________________ Office Phone ________________

Are you under medical treatment now? Yes No
What for? ________________

Have you ever been hospitalized for any surgical operation or serious illness? Yes No
What & when? ________________
____

Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medication(s) are you taking?
____
____
____

Do you use tobacco? Yes No
Type ________________
How long? ________________
Do you use alcohol,cocaine or other drugs? Yes No
Are you wearing contact lenses? Yes No

Are you allergic to or have you had any reactions to the Following? Yes No
Local anesthetics (novocaine) Yes No
Penicillin or other Antibiotics Yes No
Sulfa Drugs Yes No
Barbiturates Yes No
Sedatives Yes No
Iodine Yes No
Aspirin Yes No
Other Yes No

Patient Name ________________
Date ________________

(Please Circle All that Apply)

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 Blood Pressure	Emphysema
Glaucoma	Epilepsy/Convulsion
Cancer	Recent Weight Loss
Leukemia	Arthritis
Liver Disease	Diabetes
Joint Replacement/implant	Heart Trouble
Kidney Disease	Hepatitis/Jaundice
Respiratory Problems	Thyroid Problems
Ulcers	Stomach Troubles
Sexually Transmitted Disease	Artificial Joints

What kind? ________________
Other ________________
____

What Pharmacy do you prefer medications be called in at?
________________ **Phone** ________________

Women Only
Are you pregnant or think you may be pregnant? Yes No
Your OBGYN ________________ Phone ________________
Are you nursing? Yes No
Are you taking birth control pills? Yes No

Dental Health Questions

Are you having discomfort at this time? Yes No
Have you ever had any serious trouble associated with past dental treatment? Yes No
What kind of problems ________________
Does dental treatment make you nervous?
No Slightly Moderately Extremely
Have you ever been treated for Periodontal disease? Yes No
(gum disease, pyorrhea, trench mouth)
When ________________
How often do you brush ________ Floss ________
Is your brush Soft Medium Hard
When brushing, do you brush hard? Yes No
Date of last dental visit? ________________
Date of last full mouth x-ray? ________________
Name of previous dentist? ________________
Phone ________________

Circle any of the following that apply to your mouth

Bleeding Gums	Unpleasant taste/Bad breath
Burning tongue/lips	Frequent blisters, lips/mouth
Swelling/lumps in mouth	Ortho treatment (braces)
Biting cheeks/lips	Clicking/popping jaw
Frequent headaches	Difficult extractions
Difficulty in opening or closing	

Circle any of the following that apply to your teeth

Loose Teeth	Sensitive to hot
Sensitive to cold	Sensitive to sweets
Sensitive to biting	Food impaction
Clenching/grinding	Shifting in bite
Change in bite	

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.

Signature of Patient or parent if minor ________________ Date ________________