Patient Medical History

Patient Name _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medications are you taking?

_____

_____

_____

_____

	Yes	No
4. Have you ever been told you need to take premedication before dental treatment?	☐	☐
5. Are you wearing contact lenses?	☐	☐
6. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Latex	☐	☐
*Other*_____	☐	☐
7. Do you have or have you had the following heart issues?		
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Heart Trouble	☐	☐
8. Do you use alcohol?	☐	☐
9. Do you use tobacco?	☐	☐
10. Do you use cocaine or other recreational drugs?	☐	☐
11. Do you have sleep apnea?	☐	☐

	Yes	No
12. Do you have or have you had any of the following:		
Anemia	☐	☐
Liver Disease	☐	☐
Rheumatic Fever	☐	☐
Epilepsy/Convulsions	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Chest Pains	☐	☐
Respiratory Problems	☐	☐
Leukemia	☐	☐
Recent Weight Loss	☐	☐
Easily Winded	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Stroke	☐	☐
Stomach Troubles/Ulcers	☐	☐
Frequently Tired	☐	☐
Angina	☐	☐
Sexually Transmitted Disease	☐	☐
Hepatitis/Jaundice	☐	☐
Joint Replacement or Implant	☐	☐
Arthritis	☐	☐
Cancer	☐	☐
Glaucoma	☐	☐
Radiation Therapy	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Other	☐	☐
13.Woman only:		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Do you take birth control pills?	☐	☐

*Comments:*_____

_____

_____

Authorization and Release: *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 dental group insurance benefits otherwise payable to me.*

Name of Physician _____ *Office Phone* _____ *Last Exam* _____

Patient Medical History ***Patient Name*** _____

Patient Signature _____ ***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 or foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids or foods?	☐	☐
4. Do you have any sores or lumps in or near your your mouth?	☐	☐
5. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
6. Have you ever experienced any of the following problems with your jaw?	☐	☐
a) Clicking?	☐	☐
b) Pain(joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty chewing?	☐	☐

	Yes	*No*
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10. Have you ever had any difficult extractions in the past?	☐	☐
11. Have you ever had any prolonged bleeding following extractions?	☐	☐
12. Have you ever had instructions on the care of your gums?	☐	☐
13.Do you feel any pain to any of your teeth?	☐	☐
14. Have you ever had any orthodontic work?	☐	☐
15. Have you had any head, neck or jaw injuries?	☐	☐

16.Anything else we should know about your health _____

_____