PATIENT NAME		TODAY'S DATE	
HOME ADDRESS		DATE OF BIRTH	
		HOME PHONE	
E-MAIL		CELL PHONE	
EMPLOYER		BUSINESS PHONE	
INSURANCE CO.		SS#/SIN	

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

YES   NO

1. Are you under medical treatment now? ☐ ☐

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 medication(s) are you taking? _____

4. Have you ever taken Fen-Phen/Redux? ☐ ☐

5. Do you use tobacco? ☐ ☐

6. Do you use alcohol, cocaine or other drugs? ☐ ☐

7. Are you wearing contact lenses? ☐ ☐

8. Are you allergic to or have you had any reactions to the following?

   YES NO
   ☐ ☐ Local anesthetics (eg. novocaine)
   ☐ ☐ Penicillin or other antibiotics
   ☐ ☐ Sulfa Drugs

   YES NO
   ☐ ☐ Barbiturates
   ☐ ☐ Sedatives
   ☐ ☐ Iodine

   YES NO
   ☐ ☐ Aspirin
   ☐ ☐ Other _____
   _____

9. WOMEN ONLY: YES   NO
   a) Are you pregnant or think you may be pregnant? ☐ ☐
   b) Are you nursing? ☐ ☐
   c) Are you taking birth control pills? ☐ ☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

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

YES	NO		YES	NO		YES	NO	
☐	☐	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/High Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	_____

COMMENTS

_____
_____
_____
_____
_____
_____

Signature of Dentist _____   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/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?
   a) Clicking? ☐ ☐
   b) Pain (joint, ear, side of face)? ☐ ☐
   c) Difficulty in opening or closing? ☐ ☐
   d) Difficulty in chewing? ☐ ☐

                                                    YES   NO

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 had any orthodontic treatment? ☐ ☐

13. Have you ever had prolonged bleeding following extractions? ☐ ☐

14. Have you ever had instruction on the correct method of brushing your teeth? ☐ ☐

15. Have you ever had instructions on the care of your gums? ☐ ☐

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 _____

PATIENT, PARENT OR GUARDIAN _____   DATE _____