PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth _____ Email: _____

Address: _____ Occupation: _____

Phone: Cell: _____ Home: _____ Work: _____

Social Security # _____

	Yes	No
Are you in good health?	☐	☐
Any changes to your health in the last year?	☐	☐
Date of last physical exam: _____		
Physician's name: _____		
Address: _____		
Phone #: _____		
Have you ever been hospitalized, had major surgery or serious illness we need to know about? _____	☐	☐
Have you had any abnormal bleeding?	☐	☐
Have you ever had a blood transfusion?	☐	☐
Have you ever taken Fen-Phen/Redux?	☐	☐
If yes, any heart valve problems?	☐	☐
Do you use tobacco?	☐	☐
If yes, # of cigarettes ____ per day _____ years		
Do you or have you ever used any controlled substances? List: _____	☐	☐

	Yes	No
Are you wearing contact lenses?	☐	☐
Have you had a recent weight gain/loss?	☐	☐
Are you allergic to or have you had reactions to:		
Local anesthetics like Novocaine	☐	☐
Penicillin or other anitbiotics	☐	☐
Sulfa drugs	☐	☐
barbiturates, sedatives or sleeping pills	☐	☐
Any metals (ie: Nickel)	☐	☐
Latex/rubber	☐	☐
Iodine	☐	☐
Other (Please list) _____		
FOR WOMEN		
Are you pregnant or think you are pregnant?	☐	☐
Are you nursing?	☐	☐
Are you on Birth Control Pills?	☐	☐
Medications _____		

Do you have or have you ever had any of the following:

Heart:		
Rheumatic heart disease/Rheumatic fever	☐	☐
Mitral Valve Prolapse	☐	☐
Heart valve problem	☐	☐
Heart defect or murmur	☐	☐
Scarlett Fever	☐	☐
Angina, heart attack heart problems, chest pa	☐	☐
Pacemaker	☐	☐
Congenital heart defect	☐	☐
Medications _____		
Hepatitis A B C (please circle which one)	☐	☐
Liver Disease	☐	☐
Medications _____		
Lung problems/Breathing problems	☐	☐
Tuberculosis	☐	☐
Asthma/ Hay fever	☐	☐
Medications _____		
Depression, Anxiety, Mental Disorders	☐	☐
Medications _____		
Hypertension (high blood pressure)	☐	☐
Medications _____		
Stroke	☐	☐
Anticoagulants (Aspirin, Coumadin, Warafin etc	☐	☐
Medications _____		
Anemia	☐	☐
Arthritis or Rheumatism	☐	☐
Medications _____		

Joint Replacement	☐	☐
Which Joint? _____		
What Month _____ and Year _____		
Osteoporosis or Osteonecrosis	☐	☐
Biphosphanates(Fosamax, Boniva, Actonel etc)	☐	☐
Medications _____		
Cortisone or other Steriods Treatment	☐	☐
Diabetes	☐	☐
Medications _____		
Kidney problems	☐	☐
Medications _____		
Stomach problems	☐	☐
If so, which problem? _____		
Medications _____		
Cancer or Tumors	☐	☐
Where _____		
Cholesterol	☐	☐
Medications _____		
Chemotherapy	☐	☐
Radiation	☐	☐
Epilepsy or Seizures	☐	☐
Medications _____		
Sexually Transmitted Disease	☐	☐
Which One? _____		
HIV + or AIDS (please circle)	☐	☐
Eating Disorders	☐	☐
Which One? _____		

Lupus ….....	☐	☐	Thyroid Problems ….....	☐	☐

List any other medications (prescription or non-prescription): _____

List any other medical conditions we should know about: _____

PATIENT DENTAL HISTORY **NAME**_____

Reason for this visit_____

When was your last dental visit _____ What was done? _____

How often did you visit the dentist before then _____ Is your drinking water fluoridated? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Why did you leave your last dentist?_____

Did you ever have a bad dental experience? If so, please describe _____

Is there any issues, fears or problems you want me to know about?_____

If you play sports, which one(s) do you play?_____

	Yes	No		Yes	No
Do your gums bleed when brushing or flossing?	☐	☐	Do you bite your lips or cheek?….....	☐	☐
Are your teeth sensitive to hot or cold?	☐	☐	Have you noticed any loosening of your teeth?	☐	☐
Are your teeth sensitive to sweet or sour?	☐	☐	Does food get caught between your teeth?	☐	☐
Do you have pain on any of your teeth?	☐	☐	Have you had any periodontal treatment?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐	Have you had any difficult extractions?	☐	☐
Have you had any following problems with your jaw?			If you wear a denture, how old is it? _____		
Clicking?	☐	☐	Do you have frequent headaches?	☐	☐
Pain? Where?_____	☐	☐	Do you have sores/lumps in or near your mouth?	☐	☐
Difficulty chewing?	☐	☐	Does/Did your parents wear dentures or partials?	☐	☐
Difficulty opening or closing?	☐	☐	Do you snore?	☐	☐
Pain? Where?_____			Do you wake up tired?	☐	☐
			Do you have a sleep apnea appliance?	☐	☐

If you could change anything about your smile, what would you change?

_____

Authorization and Release

I certify that I have read and understand the above information and that 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 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 practiontioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agreed to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ **Date** _____

Signature of patient or parent/guardian of minor child

X_____ **Date** _____

Doctor Signature