## Patient's Medical History

PATIENT'S NAME _____ DATE OF BIRTH _____

**Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.**

**Please Circle Yes or No**

1. Are you in good health?..... YES NO
2. Have there been any changes in your general health within the past year..... YES NO
3. Date of your last physical exam: _____
4. Primary Care Physician, Phone Number, City, State:

_____

_____

5. Are you under the care of a physician..... YES NO
6. Have you had any abnormal bleeding ..... YES NO
7. Do you bruise easily..... YES NO
8. Have you ever required a blood transfusion ..... YES NO
9. Have you had recent weight loss ..... YES NO
10. Have you ever been hospitalized for any surgical operation Or serious illness..... YES NO
    If yes, please explain _____
    _____
11. Have you ever taken Fen-Phen/Redux..... YES NO
12. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing Bisphosphonates..... YES NO
13. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours..... YES NO
14. Do you use tobacco..... YES NO
15. Do you or have you used controlled substances... YES NO
16. Are you wearing contact lenses..... YES NO
17. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..... YES NO
18. Do you have any disease, condition or problem not listed above that you think I should know about ..... YES NO

**Women Only**

Are you pregnant or think you may be..... YES NO
Are you nursing..... YES NO
Are you taking birth control pills ..... YES NO

**Are you allergic to or have you had reactions to:**

Local Anesthetics Like Novocaine..... YES NO
Penicillin or Other Antibiotics..... YES NO
Sulfa Drugs..... YES NO
Barbiturates, Sedatives or Sleeping Pills..... YES NO
Aspirin..... YES NO
Iodine..... YES NO
Any Metal (E.G., Nickel, Mercury, etc.)..... YES NO
Latex/Rubber..... YES NO
Other (please list) _____

**Do you have or have you ever had the following:**

Rheumatic Heart Disease or Rheumatic Fever ..... YES NO
Scarlet Fever ..... YES NO
Heart Defect or Heart Murmur ..... YES NO
Heart Trouble, Heart Attack, or Angina..... YES NO
Chest Pain ..... YES NO
Shortness of Breath..... YES NO
Pacemaker..... YES NO
Heart Surgery..... YES NO
Circle One: High or Low Blood Pressure..... YES NO
Congenital Heart Problem..... YES NO
Swelling of Feet, Ankles, Hands..... YES NO
Hepatitis, Jaundice or Liver Disease..... YES NO
Stroke..... YES NO
Sinus Trouble ..... YES NO
Lung or Breathing Problems..... YES NO
Asthma or Hay Fever..... YES NO
AIDS or HIV Infections..... YES NO
Hives or Skin Rash..... YES NO
Fainting or Dizzy Spells..... YES NO
Diabetes..... YES NO
Thyroid Problems..... YES NO
Allergies..... YES NO
Arthritis or Rheumatism ..... YES NO
Joint Replacement or Implant ..... YES NO
Stomach Ulcer ..... YES NO
Kidney Trouble..... YES NO
Tuberculosis ..... YES NO
Persistent Cough ..... YES NO
Cough That Produces Blood ..... YES NO
Chemotherapy (Cancer, Leukemia) ..... YES NO
Sexually Transmitted Disease ..... YES NO
Epilepsy or Seizures ..... YES NO
Anemia..... YES NO
Glaucoma..... YES NO
Nervousness..... YES NO
Tonsillitis..... YES NO
Tumors..... YES NO
Mental Health Care..... YES NO
Back Problems..... YES NO
Chemical Dependency..... YES NO
Mitral Valve Prolapse..... YES NO
Cortisone Treatment..... YES NO
Cold Sores/Fever Blisters..... YES NO
Hypoglycemia..... YES NO
Eating Disorders..... YES NO

**Patient's Medical History**

PATIENT'S NAME _____ DATE OF BIRTH _____

Are you taking any medicine(s) including non-prescription medicine…….. YES NO
If yes, what medicine(s) are you taking:

| Name of Medication | Dosage | Purpose | Prescribing Physician | Date Started | Date Stopped |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Reason for this visit _____
When was your last dental visit _____What was done then_____
How often did you visit the dentist before then _____
Previous Dentist (Name and Location) _____
How often did you visit the Dentist before then _____

Do your gums bleed while brushing or flossing……YES NO
Are your teeth sensitive to hot or cold liquids/foods…… YES NO
Are your teeth sensitive to sweet or sour liquids/foods…….. YES NO
Do you feel pain to any of your teeth…… YES NO
Do you have any sores or lumps in or near your mouth…… YES NO
Have you had any head, neck or jaw injuries…….. YES NO
Have you ever experienced any of the following problems in your jaw?
Clicking…….. YES NO
Pain (Joint, ear, side of face)…….. YES NO
Difficulty in opening or closing …….. YES NO
Difficulty in chewing…….. YES NO

Have you ever had periodontal treatment (gums)…..YES NO
Have you ever had any difficult extractions in the past…….. YES NO
Have you ever had any prolonged bleeding following extractions……..YES NO
Do you have frequent headaches……YES NO
Do you clench or grind your teeth……..YES NO

**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 to third party payors and/or health practitioners. 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 agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

**Signature of Patient or Parent/Guardian if Minor** **Date**

Doctor's Comments

_____

_____

**Dentist's Signature** **Date**