Print Form

Patient Name _____ Date _____ Phone # _____
Date of Birth _____ SS # _____ E-Mail _____

PATIENT MEDICAL HISTORY

Physician _____ 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) Do you use tobacco?	☐	☐
5) Do you use alcohol or other drugs?	☐	☐
6) Are you wearing contact lenses?	☐	☐
7) Do you have or have you been diagnosed With a sleep disorder?	☐	☐

8) Are you allergic to or have had any reactions to the following:

Yes	No		Yes	No	
☐	☐	Local Anesthetics	☐	☐	Aspirin
☐	☐	Penicillin or other	☐	☐	Sedatives
☐	☐	Antibiotics	☐	☐	Latex
☐	☐	Barbiturates	☐	☐	Iodine
☐	☐	Sulfa Drugs	☐	☐	Other _____

	Yes	No
9) Women only:		
A) Are you pregnant or think you may be?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking birth control pills?	☐	☐
10) Do you need to be premedicated?	☐	☐

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

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS or HIV Infection	☐	☐	Frequently Tired	☐	☐	Low Blood Pressure
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Radiation Therapy
☐	☐	Angina	☐	☐	Hay Fever/Allergies			Recent Weight Loss
☐	☐	Arthritis	☐	☐	Heart Attack	☐	☐	Respiratory Problems
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	STD
☐	☐	Cardiac Pacemaker	☐	☐	Heart Trouble	☐	☐	Stomach Troubles
☐	☐	Chest Pains	☐	☐	Hepatitis/Jaundice	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Swollen Ankles
☐	☐	Easily Winded	☐	☐	Joint Replacement	☐	☐	Thyroid Problem
☐	☐	Emphysema	☐	☐	Kidney Disease	☐	☐	Tuberculosis
☐	☐	Epilepsy/Convulsions	☐	☐	Leukemia	☐	☐	Other _____
☐	☐	Fainting/Seizures	☐	☐	Liver Disease			_____

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 you mouth?	☐	☐
6) Have you had any head, neck, or jaw injuries?	☐	☐
7) Have you ever experienced any of the following Problems in you 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?		
11) Have you ever had any difficult Extractions in the past?	☐	☐
12) Have you ever had any orthodontics?		
13) Have you ever had prolonged Bleeding following extractions?	☐	☐
14) Have you ever had instructions on The correct method of brushing?	☐	☐
15) Have you ever had instructions on The care of your gums?	☐	☐

SIGNATURE

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.

X_____ **X**_____

Patient, Parent or Guardian Signature **Doctor Signature** **Date**