PATIENT MEDICAL HISTORY

Date _____

Patient Name _____ Sex: M F
LAST FIRST MIDDLE

Social Security Number _____

Address _____ Marital Status: S M W D
STREET CITY STATE ZIP

Personal Responsible for Payment _____ Address _____

Home Phone _____ Business Phone _____ Employer _____ Occupation _____

Date of birth _____ Who referred you to our office? _____

Physician Name, Address & Phone _____

Welcome to our office. The following questions about your health will aid us in providing the best dental treatment for you. Please remember that the answers to these questions are held in strict confidence. If you have any questions, please feel free to ask. Thank you.

1. Date of last physical examination _____
2. Are you under any medical treatment now? If so, what? . . . . . yes no
3. Have you been hospitalized in the last five years? . . . . . yes no
4. Have you had any major operations? If so, what? . . . . . yes no
5. Have you had abnormal bleeding after cuts, surgery or dental extractions? . . . . . yes no
6. Have you had surgery or x-ray treatment for a tumor, growth or other condition? . . . . . yes no
7. Are you employed anywhere that exposes you to x-ray or ionizing radiation? . . . . . yes no
8. Are you now taking drugs, medicine or pills?* . . . . . yes no
9. Are you currently taking any bisphosphonate drugs?* . . . . . yes no

*If so, please list:

Name	Dosage	Frequency	Date Started

10. Do you have or have you ever had: (check any that apply)

- ❑ heart ailment
- ❑ rheumatic heart disease
- ❑ heart attack
- ❑ artificial heart valve or pacemaker
- ❑ chest pain
- ❑ shortness of breath
- ❑ high blood pressure
- ❑ stroke
- ❑ respiratory or lung disease
- ❑ tuberculosis
- ❑ scarlet fever or rheumatic fever
- ❑ asthma
- ❑ emphysema
- ❑ persistent cough
- ❑ recurrent sore throat
- ❑ sinus trouble
- ❑ hay fever
- ❑ allergy
- ❑ skin rashes
- ❑ epilepsy or seizures
- ❑ fainting spells
- ❑ liver disease
- ❑ hepatitis or yellow jaundice
- ❑ kidney disease
- ❑ tested for HIV
- ❑ anemia
- ❑ blood disease or disorder
- ❑ diabetes
- ❑ arthritis
- ❑ venereal disease or syphilis
- ❑ stomach ulcer
- ❑ tumor or growth
- ❑ thyroid problem or hormone deficiency
- ❑ glaucoma or other eye problems
- ❑ contact lenses

– Over Please –

11. Are you allergic to, or have you ever reacted adversely to: (check any that applies)

- ❑ local anesthetic (such as novocaine)
- ❑ penicillin or other antibiotic
- ❑ sulfa drugs
- ❑ aspirin
- ❑ codeine
- ❑ sedatives, barbiturates, or sleeping pills
- ❑ iodine
- ❑ other _____

12. Is there any condition you feel your dentist should know about before undertaking dental treatment?

If so, explain: _____

_____

13. Women: Are you pregnant or think you may be? ..... yes no

PATIENT DENTAL HISTORY

1. What is the reason for your present visit? _____

_____

2. Date of last visit to the dentist _____
3. Was all treatment completed? ..... yes no
4. Have you ever had a tooth removed? ..... yes no

   If so, why and was a replacement advised? _____
5. Are any of your teeth painful or sensitive? ..... yes no
6. Do your gums bleed easily? ..... yes no
7. Have you ever been told you have gum disease (periodontal disease or pyorrhea)? ..... yes no
8. Have you ever had gum (periodontal) treatment? ..... yes no
9. Do you get canker sores in your mouth? If so, how often? ..... yes no
10. Do you get fever blisters in your mouth? If so, how often? ..... yes no
11. Have you ever had a local anesthetic (has your jaw ever been put to sleep? ..... yes no
12. Have you had any previous difficulties associated with previous dental treatment? ..... yes no
13. Do you have frequent headaches? If so, how often? ..... yes no
14. Does your jaw ever pop? ..... yes no
15. Do you ever have any discomfort around your ears, eyes, throat, neck or shoulders? ..... yes no
16. Does it hurt to open wide or take a big bite? ..... yes no
17. Does it hurt to chew? ..... yes no
18. Do you feel that you can chew adequately? ..... yes no
19. Have you ever had instruction in the use of a toothbrush and dental floss? ..... yes no
20. How often do you brush your teeth? _____ Floss? _____
21. Do you use a hard or soft toothbrush?_____
22. Is there any dental condition that you feel the dentist should know about? ..... yes no

    If so, please explain: _____

I certify that the above information is correct to the best of my knowledge. I hereby consent to such examinations, x-rays, photographs and diagnostic procedures and test you may prescribe.

Signature _____ Date _____