

# Patient 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.

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Are you in good health _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the past year _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam _____  |                          |                          |
| 4. Physician's name _____<br>Address _____<br>Phone no. _____   |                          |                          |
| 5. Are you now under the care of a physician _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been hospitalized for any surgical operation or serious illness _____<br>Please explain _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you taking any medicine(s), including non-prescription medicine? _____<br>If yes, what medicine(s) are you taking _____<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 8. Have you had any abnormal bleeding _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you bruise easily _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever required a blood transfusion _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had a recent weight loss _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever taken Fen-Phen or Redux _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you use tobacco _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you or have you used controlled substances _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you wearing contact lenses _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have any disease, condition, or problem not listed above that you think I should know about _____ | <input type="checkbox"/> | <input type="checkbox"/> |

**Women only:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Are you pregnant or think you may be pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking birth control pills _____            | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Are you allergic to or have you had reactions to: |                          |                          |
| Local anesthetics like novocaine _____            | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics _____             | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs _____                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates, sedatives, or sleeping pills _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine _____                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Any metals (e.g., nickel, mercury, etc.) _____    | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex/rubber _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list) _____                         |                          |                          |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Do you have, or have you ever had, any of the following: |                          |                          |
| Rheumatic heart disease or rheumatic fever _____         | <input type="checkbox"/> | <input type="checkbox"/> |
| Scarlet fever _____                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart defect or heart murmur _____                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart trouble, heart attack, or angina _____             | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart surgery _____                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| High/low blood pressure _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart problem _____                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of feet, ankles, hands _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis, jaundice, or liver disease _____              | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus trouble _____                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung or breathing problems _____                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma or hay fever _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Hives or skin rash _____                                 | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                       | YES                      | NO                       |
|---------------------------------------|--------------------------|--------------------------|
| Fainting or dizzy spells _____        | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes _____                        | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV infection _____           | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problem _____                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies _____                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis or rheumatism _____         | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement or implant _____    | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach ulcer _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney trouble _____                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough _____                | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough that produces blood _____       | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy (cancer, leukemia) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually transmitted disease _____    | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or seizures _____            | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma _____                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervousness _____                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Tonsillitis _____                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumors _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental health care _____              | <input type="checkbox"/> | <input type="checkbox"/> |
| Back problems _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemical dependency _____             | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse _____           | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone treatment _____             | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold sores/fever blisters _____       | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypoglycemia _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating disorders _____                | <input type="checkbox"/> | <input type="checkbox"/> |

# Patient Medical History

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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) \_\_\_\_\_

Have you had a complete series of dental exams (x-rays) taken? When and where \_\_\_\_\_

How often do you brush your teeth \_\_\_\_\_ How often do you floss your teeth \_\_\_\_\_

Is your drinking water fluoridated \_\_\_\_\_

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any loosening of your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods _____	<input type="checkbox"/>	<input type="checkbox"/>	Does food tend to become caught between your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had periodontal treatment (gums) _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn a bite plate or other appliance _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions in the past _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any prolonged bleeding following extractions _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw?			Do you wear dentures or partials _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking _____	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face) _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth and gums _____	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you had ortho/braces in the past _____	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing _____	<input type="checkbox"/>	<input type="checkbox"/>	Would you be interested in teeth whitening _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an unfavorable dental experience _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>			
Do you bite your lips or cheeks frequently _____	<input type="checkbox"/>	<input type="checkbox"/>			

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

\_\_\_\_\_

**Appointments:** A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

## 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 my 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.

X \_\_\_\_\_ Date \_\_\_\_\_

Signature of patient or parent if minor

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Patient Number

