

PATIENT NAME _____ HOME ADDRESS _____ _____ E-MAIL _____ EMPLOYER _____ INSURANCE CO. _____	TODAY'S DATE _____ DATE OF BIRTH _____ HOME PHONE _____ CELL PHONE _____ BUSINESS PHONE _____ SS#/SIN _____
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PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

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| <p style="text-align: center;">YES NO</p> <p>1. Are you under medical treatment now? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 20px;">If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Do you use tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Do you use alcohol, cocaine or other drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Are you wearing contact lenses? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>8. Are you allergic to or have you had any reactions to the following?</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">YES NO</td> <td style="text-align: center;">YES NO</td> <td style="text-align: center;">YES NO</td> </tr> <tr> <td><input type="checkbox"/> Local anesthetics (eg. novocaine)</td> <td><input type="checkbox"/> Barbiturates</td> <td><input type="checkbox"/> Aspirin</td> </tr> <tr> <td><input type="checkbox"/> Penicillin or other antibiotics</td> <td><input type="checkbox"/> Sedatives</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Sulfa Drugs</td> <td><input type="checkbox"/> Iodine</td> <td></td> </tr> </table> <p>9. WOMEN ONLY:</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c) Are you taking birth control pills? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | YES NO | YES NO | YES NO | <input type="checkbox"/> Local anesthetics (eg. novocaine) | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Iodine | |
| YES NO | YES NO | YES NO | | | | | | | | | | | |
| <input type="checkbox"/> Local anesthetics (eg. novocaine) | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Aspirin | | | | | | | | | | | |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Other _____ | | | | | | | | | | | |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Iodine | | | | | | | | | | | | |

11. Do you have or have you had any of the following?
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| <p style="text-align: center;">YES NO</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Swollen Ankles</p> <p><input type="checkbox"/> Fainting / Seizures</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Low/High Blood Pressure</p> <p><input type="checkbox"/> Epilepsy / Convulsions</p> <p><input type="checkbox"/> Leukemia</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Kidney Diseases</p> <p><input type="checkbox"/> AIDS or HIV Infection</p> <p><input type="checkbox"/> Thyroid Problem</p> | <p style="text-align: center;">YES NO</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Cardiac Pacemaker</p> <p><input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> Angina</p> <p><input type="checkbox"/> Frequently Tired</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Joint Replacement or Implant</p> <p><input type="checkbox"/> Hepatitis / Jaundice</p> <p><input type="checkbox"/> Sexually Transmitted Disease</p> <p><input type="checkbox"/> Stomach Troubles / Ulcers</p> | <p style="text-align: center;">YES NO</p> <p><input type="checkbox"/> Chest Pains</p> <p><input type="checkbox"/> Easily Winded</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Hay Fever / Allergies</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Recent Weight Loss</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> Respiratory Problems</p> <p><input type="checkbox"/> Other _____</p> |
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COMMENTS

Signature of Dentist _____ Date _____

PATIENT DENTAL HISTORY

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| <p style="text-align: center;">YES NO</p> <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Have you ever experienced any of the following problems in your jaw?</p> <p style="margin-left: 20px;">a) Clicking? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 20px;">b) Pain (joint, ear, side of face)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 20px;">c) Difficulty in opening or closing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 20px;">d) Difficulty in chewing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p style="text-align: center;">YES NO</p> <p>8. Do you have frequent headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. Have you had any orthodontic treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. Have you ever had prolonged bleeding following extractions? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. Have you ever had instruction on the correct method of brushing your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>15. Have you ever had instructions on the care of your gums? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
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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.

SIGNATURE	X _____	_____ <small>DATE</small>
	PATIENT, PARENT OR GUARDIAN	