PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

EMPLOYER _____ BUSINESS PHONE _____

INSURANCE CO. _____ SS#/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE 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, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other _____
☐	☐	Sulfa Drugs	☐	☐	Iodine			_____

8. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

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

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Easily Winded
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Stroke
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Hay Fever / Allergies
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Tuberculosis
☐	☐	Fainting / Seizures	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Asthma	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Low/High Blood Pressure	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Epilepsy / Convulsions	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Leukemia	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse
☐	☐	Diabetes	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	Kidney Diseases	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____
☐	☐	AIDS or HIV Infection	☐	☐	Stomach Troubles / Ulcers	☐	☐	_____
☐	☐	Thyroid Problem	☐	☐	Chest Pains	☐	☐	_____

COMMENTS

_____

_____

_____

_____

_____

_____

_____

Signature of Dentist Date

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 your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your 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 frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

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 _____ _____

PATIENT, PARENT OR GUARDIAN DATE