**PATIENT**

**NAME**

**PATIENT NAME \_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-MAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE CO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#/SIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT MEDICAL HISTORY**

PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OFFICE PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_\_\_\_\_\_\_

YES NO

❑ ❑

❑ ❑

❑ ❑

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

YES NO YES NO YES NO

❑ ❑ Local anesthetics ❑ ❑ Barbiturates ❑ ❑ Aspirin

(eg. Novocaine)

❑ ❑ Penicillin or other ❑ ❑ Sedatives ❑ ❑ Other

Antibiotics \_\_\_\_\_\_\_\_\_\_

❑ ❑ Sulfa Drugs ❑ ❑ Iodine \_\_\_\_\_\_\_\_\_\_

1. 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? ❑ ❑

1. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?) ❑ ❑
2. Are you under medical treatment now?
3. Have you ever been hospitalized for any surgical operation or serious illness?
4. Are you taking any medication (s) including non-prescription medicine?

If yes, what medication(s) are you taking?

1. Have you ever taken Fen-Phen/Redux?
2. Do you use tobacco?
3. Do you use alcohol, cocaine or other drugs?
4. Are you wearing contact lenses?

❑ ❑

❑ ❑

❑ ❑

❑ ❑

COMMENTS

Signature of Dentist Date

11. Do you have or have you had any of the following? Yes/No

❑ ❑ High Blood Pressure

❑ ❑ Heart attack

❑ ❑ Rheumatic Fever

❑ ❑ Swollen Ankles

❑ ❑ Fainting / Seizures

❑ ❑ Asthma

❑ ❑ Low/High Blood Pressure

❑ ❑ Epilepsy / Convulsions

❑ ❑ Leukemia

❑ ❑ Diabetes

❑ ❑ Kidney Diseases

❑ ❑ AIDS or HIV Infection

❑ ❑ Thyroid Problem

❑ ❑ Heart Disease

❑ ❑ Cardiac Pacemaker

❑ ❑ Heart Murmur

❑ ❑ Angina

❑ ❑ Frequently Tired

❑ ❑ Anemia

❑ ❑ Emphysema

❑ ❑ Cancer

❑ ❑ Arthritis

❑ ❑ Joint Replacement or Implant

❑ ❑ Hepatitis / Jaundice

❑ ❑ Sexually Transmitted Disease

❑ ❑ Stomach Troubles / Ulcers

❑ ❑ Chest Pains

❑ ❑ Easily Winded

❑ ❑ Stroke

❑ ❑ Hay Fever / Allergies

❑ ❑ Tuberculosis

❑ ❑ Radiation Therapy

❑ ❑ Glaucoma

❑ ❑ Recent Weight Loss

❑ ❑ Liver Disease

❑ ❑ Heart Trouble

❑ ❑ Respiratory Problems

❑ ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_

❑ ❑ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DENTAL HISTORY**

YES NO

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? ❑ ❑

* 1. Clicking? ❑ ❑
  2. Pain (joint, ear, side of face)? ❑ ❑
  3. Difficult in opening or closing? ❑ ❑
  4. Difficult in chewing? ❑ ❑

1. Do you have frequent headaches? ❑ ❑
2. Do you clench or grind your teeth? ❑ ❑
3. Do you bite your lips or cheeks frequently? ❑ ❑
4. Have you ever had any difficult extractions in the past? ❑ ❑
5. Have you had any orthodontic treatment? ❑ ❑
6. Have you ever had prolonged bleeding following extractions? ❑ ❑
7. Have you ever had instruction on the correct method of

brushing your teeth? ❑ ❑

1. 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT, PARENT OR GUARDIAN DATE