Patient Medical History

Physician_____ Office #_____ 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 in the last 5 yrs? If yes, please explain. _____	☐	☐
3. Are you taking medication(s)? Including Non-prescription medicine? If yes, what medications are you taking?_____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco	☐	☐
6. Do you use a controlled substance?	☐	☐
7. Have you ever taken a Bisphosphonate (Fosamax, Bioniva, Didronel)	☐	☐

9. Are you allergic to or have you had any reactions to:	YES	NO
Local Anesthetic (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____	☐	☐
Women Only:		
a) Are you pregnant or think you may be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptive?	☐	☐

8. Do you have any of the Following? *(Please Circle Yes or No)*

High blood pressure	Yes	No	Heart Disease	Yes	No	Chest Pain	Yes	No
Heart Attack	Yes	No	Cardiac Pacemaker	Yes	No	Osteoporosis	Yes	No
Rheumatic Fever	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Swollen Ankles	Yes	No	Angina	Yes	No	Hay fever/ Allergies	Yes	No
Fainting/ Seizures	Yes	No	Frequent Headaches	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Anemia	Yes	No	Radiation Therapy	Yes	No
Low Blood Pressure	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Epilepsy/ Convulsions	Yes	No	Cancer	Yes	No	Recent Weight Loss	Yes	No
Leukemia	Yes	No	Arthritis	Yes	No	Liver Disease	Yes	No
Diabetes	Yes	No	Joint Replacement or Implant	Yes	No	Heart Trouble	Yes	No
Kidney Diseases	Yes	No	Hepatitis/ Jaundice	Yes	No	Respiratory Problems	Yes	No
AIDS or HIV Infection	Yes	No	Sexually Transmitted Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Thyroid problem	Yes	No	Stomach Troubles/ Ulcers	Yes	No	Other_____		

Patient Dental History

Name of Previous Dentist and Location_____Date of last Exam_____

1. Do your gums bleed while brushing or flossing?	Yes	No
2. Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
3. Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
4. Do you feel pain to any of your teeth?	Yes	No
5. Do you have any sores or lumps in or near your mouth?	Yes	No
6. Have you had any head, neck or jaw injuries?	Yes	No
7. Have you ever experienced any if the following problems in your jaw?		
a) Clicking	Yes	No
b) Pain (joint, ear, side of face)	Yes	No
c) Difficulty in opening or closing	Yes	No
d) Difficulty in chewing	Yes	No
8. Have you had your wisdom teeth removed?	Yes	No
9. Do you clench or grind your teeth?	Yes	No
10. Do you bite your lips/ cheeks frequently?	Yes	No
11. Have you ever had any difficult extractions in the past?	Yes	No
12. Have you ever had any prolonged bleeding following extractions?	Yes	No
13. Have you had any orthodontic treatment?	Yes	No
14. Do you wear dentures or partials?	Yes	No
If yes, date of placement_____		
15. Do you like your smile?	Yes	No

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 any 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 service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)