PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SOC. SEC. NO. _____

PATIENT NAME

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 ANY DRUGS? IF YES, PLEASE SPECIFY.

_____

_____

8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____

9. 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?	☐	☐

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ CHEST PAINS	☐ KIDNEY DISEASES
☐ HEART ATTACK	☐ CARDIAC PACEMAKER	☐ EASILY WINDED	☐ AIDS OR HIV INFECTION
☐ RHEUMATIC FEVER	☐ HEART MURMUR	☐ STROKE	☐ THYROID PROBLEM
☐ SWOLLEN ANKLES	☐ ANGINA	☐ HAY FEVER / ALLERGIES	☐ HEPATITIS / JAUNDICE
☐ FAINTING / SEIZURES	☐ FREQUENTLY TIRED	☐ TUBERCULOSIS	☐ SEXUALLY TRANSMITTED DISEASE
☐ ASTHMA	☐ ANEMIA	☐ RADIATION THERAPY	☐ STOMACH TROUBLES / ULCERS
☐ LOW BLOOD PRESSURE	☐ EMPHYSEMA	☐ GLAUCOMA	☐ RESPIRATORY PROBLEMS
☐ EPILEPSY / CONVULSIONS	☐ CANCER	☐ RECENT WEIGHT LOSS	☐ OTHER _____
☐ LEUKEMIA	☐ ARTHRITIS	☐ LIVER DISEASE	_____
☐ DIABETES	☐ JOINT REPLACEMENT OR IMPLANT	☐ HEART TROUBLE	_____

COMMENTS

_____

_____

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

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? ☐
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 WORK? ☐
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.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE