PATIENT MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NUMBER _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE (S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE (S) _____	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
ASPIRIN	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX/RUBBER	☐	☐

OTHER (PLEASE LIST) _____

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY	YES	NO
BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
ANGINA	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE OR HEART ATTACK	☐	☐
LUNG OR BREATHING PROBLEMS OR ASTHMA	☐	☐
HAVE YOU HAD ANY UNUSUAL PROLONGED BLEEDING	☐	☐
DO YOU BRUISE EASILY	☐	☐
HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐

	YES	NO
DO YOU USE TOBACCO	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTIONS OR STD'S	☐	☐
THYROID PROBLEMS	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
BACK PROBLEMS	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
CANCER	☐	☐
EPILEPSY OR SEIZURES	☐	☐
CORTISONE TREATMENT (STEROIDS)	☐	☐

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT

_____

_____

PATIENT NUMBER

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT, COLD, SUGARS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? CLICKING / PAIN	☐	☐
DIFFICULTY IN OPENING , CLOSING OR CHEWING	☐	☐

	YES	NO
HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH.	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

_____

_____

_____

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 PAYERS AND/OR HEALTH PRACTITIONERS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

DOCTOR'S COMMENTS _____

_____

_____

_____ _____

DOCTOR'S SIGNATURE DATE

_____

PATIENT NUMBER

HEALTH HISTORY