PATIENT MEDICAL HISTORY

PATIENT NAME

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW? IF YES, WHY? _____	☐	☐
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 HAVE ARTIFICIAL HEART VALVES?	☐	☐
5. ARE YOU OR DO YOU HAVE OSTEOPOROSIS?	☐	☐
6. DO YOU USE TOBACCO?	☐	☐
7. DO YOU HAVE CONGENITAL HEART DISEASE?	☐	☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

	YES	NO
ASPIRIN	☐	☐
CODEINE	☐	☐
IODINE	☐	☐
LATEX	☐	☐
LOCAL ANESTHETICS (E.G. NOVOCAINE)	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SEDATIVES	☐	☐
SULFA DRUGS	☐	☐
OTHER	☐	☐

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
ANGINA	☐	☐	HEART ATTACK	☐	☐	RESPIRATORY PROBLEMS	☐	☐
ASTHMA	☐	☐	HEART DISEASE	☐	☐	RHEUMATIC FEVER	☐	☐
CANCER	☐	☐	HEART MURMUR	☐	☐	STOMACH TROUBLES / ULCERS	☐	☐
CARDIAC PACEMAKER	☐	☐	HEART TROUBLE	☐	☐	STROKE	☐	☐
CHEST PAINS	☐	☐	HEPATITIS / JAUNDICE	☐	☐	SWOLLEN ANKLES	☐	☐
DIABETES	☐	☐	HIGH BLOOD PRESSURE	☐	☐	THYROID PROBLEM	☐	☐
EASILY WINDED	☐	☐	HIV/AIDS	☐	☐	TUBERCULOSIS	☐	☐
EMPHYSEMA	☐	☐	JOINT REPLACEMENT	☐	☐	OTHER	☐	☐
EPILEPSY / CONVULSIONS	☐	☐	KIDNEY DISEASES	☐	☐			
FAINTING / SEIZURES	☐	☐	LEUKEMIA	☐	☐			
FREQUENTLY TIRED	☐	☐	LIVER DISEASE	☐	☐			
GLAUCOMA	☐	☐	LOW BLOOD PRESSURE	☐	☐			
HAY FEVER / ALLERGIES	☐	☐	RADIATION THERAPY	☐	☐			

COMMENTS

SIGNATURE OF DENTIST DATE

DENTAL HISTORY SURVERY

	YES	NO
1. WHEN WAS YOUR LAST CLEANING? _____		
2. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
4. DO YOU AVOID ANY LIQUIDS/FOODS?	☐	☐
5. DO YOU GET COLD SORES OR FEVER BLISTERS?	☐	☐
6. DO YOU ROUTINELY HAVE 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?	☐	☐
E) FREQUENT HEADACHES?	☐	☐
F) CLENCH OR GRIND?	☐	☐
G) SORE JAW IN MORNING OR EVENING?	☐	☐

	YES	NO
7. HAVE YOU HAD A DIFFICULT OR UNPLEASANT DENTAL PROCEDURE IN THE PAST?	☐	☐
8. DO YOU HAVE DENTAL ANXIETY?	☐	☐
9. HAVE YOU HAD ANY ORTHODONTIC WORK (BRACES)?	☐	☐
10. ARE YOU INTERESTED IN STRAIGHTENING YOUR TEETH?	☐	☐
11. IF YOU ARE MISSING TEETH, DO YOU WISH TO REPLACE THE MISSING TEETH?	☐	☐
12. ARE YOU INTERESTED IN WHITENING YOUR TEETH?	☐	☐

SIGNATURE

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