Patient Medical History

Physician________________________Office Phone______________ Date of last exam ________

Please circle yes or no on each category. If you are unsure put a question mark.

1. Are you under Medical treatment now?.......... Yes No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last five years? If yes please explain...... Yes No

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3. Are you taking any medications- including non-prescription medication?.......................... Yes No

List all medication ________________________

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4. Have you ever taken Phen-Fen/Redux?........ Yes No

5. Do you use tobacco?.. Yes No

6. Do you use controlled substances?.............. Yes No

7. Are you wearing contact lenses?.................. Yes No

9. Are you allergic to or had a reaction to the following?

Local Anesthetic (e.g. Novocain)........ Yes No
Penicillin or other Antibiotics............ Yes No
Sulfa Drugs.................................... Yes No
Barbiturates.................................... Yes No
Sedatives.. Yes No
Iodine.. Yes No
Aspirin... Yes No
Any Metals (e.g. nickel, mercury, ect.) Yes No
Latex Rubber (gloves)........................ Yes No
Other (please list)............................. Yes No

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10. Women Only:

a.) Are you pregnant or think you might be?........ Yes No
b.) Are you nursing?.. Yes No
c.) Are you taking oral contraceptives?.................Yes No

8. Do you have or have you had any of the following?

High Blood Pressure.........	Yes	No	Heart Disease...............	Yes	No	Chest Pain......................	Yes	No
Heart Attack.................	Yes	No	Cardiac Pacemaker.........	Yes	No	Easily Winded.................	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	Emphysema..................	Yes	No	Turberculosis..................	Yes	No
Low Blood Pressure.........	Yes	No	Arthritis........................	Yes	No	Glaucoma........................	Yes	No
Epilepsy/Convulsion.........	Yes	No	Thyroid Problems...........	Yes	No	Recent Weight Loss..........	Yes	No
Leukemia.......................	Yes	No	Frequently Tired............	Yes	No	Liver Disease..................	Yes	No
Diabetes.........................	Yes	No	Hepatitis/Jaundice..........	Yes	No	Heart Trouble..................	Yes	No
Kidney Disease...............	Yes	No	Anemia...........................	Yes	No	Respiratory Problems..........	Yes	No
AIDS or HIV Infection......	Yes	No	Mitral Valve Prolapse......	Yes	No	Stomach Troubles/Ulcers.....	Yes	No
Asthma...........................	Yes	No	Cancer...........................	Yes	No	Radiation Therapy.............	Yes	No
Joint Replacement or Implant...	Yes	No	Sexually Transmitted Disease...	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 around your mouth?..Yes No

6. Have you had any head neck or jaw injuries?..................Yes No

7. Have you ever experienced any of the following problems in your jaw?

Clicking..Yes No
Pain (joint, ear, side of face)?..Yes No
Difficulty in opening or closing your jaw?.......................Yes No
Difficulty in chewing?...Yes No

8. Do you have frequent headaches?.....................Yes No

9. Do you clench or grind your teeth?...................Yes No

10. Do you bite your lips or 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

15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....Yes No

16. 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, and have accurately answered the questions. 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 authorize and request my insurance plan to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental plan 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 dependants.

Signature of Patient, Parent or Guardian: ______________________________ Date: __________

Doctors Comments: ____

Doctor's Signature: ______________________________ Date: __________