Patient Medical History

Patient's Name ________________ Date _______

Physician ______________ Office Phone _______ Date of Last Medical Exam _______ Age ________

1. Have you ever had any of the following? (Check all that apply):

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Attack	☐	☐	Sinus Problems	☐	☐	Cancer
☐	☐	Angina	☐	☐	Hepatitis or Jaundice	☐	☐	Leukemia
☐	☐	Cardiac Pacemaker	☐	☐	Liver Problems	☐	☐	Radiation Therapy
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	HIV Positive
☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐	AIDS or ARC
☐	☐	Stroke	☐	☐	Arthritis	☐	☐	Immunosuppressive Therapy
☐	☐	Bleeding Problems	☐	☐	Implant or Prosthesis			
☐	☐	Respiratory Problem	☐	☐	Epilepsy or Seizures	☐	☐	Venereal Disease
☐	☐	Tuberculosis	☐	☐	Nervous Disorder	☐	☐	Psychiatric Therapy
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Recent Weight Loss
☐	☐	Allergies	☐	☐	Thyroid Disorder	☐	☐	Other

2. Are you under medical treatment now? ____

3. List all medications you are taking: ____

____

4. Are you allergic to latex or any medications? _______________________________________

5. Have you ever had an adverse reaction to local anesthetic? ____________________________

6. Have you ever had complications following dental treatment? __________________________

7. Do you have any medical conditions not listed above? _______________________________

8. Women, are you nursing or pregnant? _________ Trimester _________ Due Date __________

9. Do you use tobacco products? ____________ Type _______________ Amount ___________

10. Who should we contact in an emergency? ___________________________ Phone ___________

Patient Dental History

YES	NO		YES	NO	
☐	☐	1. Do your gums bleed while brushing or flossing?	☐	☐	7. Have any teeth become discolored?
☐	☐	2. Are your teeth sensitive to hot or cold?	☐	☐	8. Do you have difficulty chewing?
☐	☐	3. Are your teeth sensitive to sweet or sour?	☐	☐	9. Do you have any sores or lumps in your mouth?
☐	☐	4. Do any teeth feel sore or ache?	☐	☐	10. Have you had any head, neck, or jaw injuries?
☐	☐	5. Do any teeth hurt when you chew?	☐	☐	11. Do you have pain in your jaw joint or ear?
☐	☐	6. Have your teeth shifted or moved?	☐	☐	12. Do you hear clicking or popping sounds when opening or closing your mouth?

I have read and understand the information above. To the best of my knowledge, the questions above have been accurately answered. I understand that incorrect information can be dangerous to my health.

Signature ____________________________________ Date ________________

Signature of Patient or Parent or Guardian