Patient Medical History

Patient Name:_____ **Date of Birth:**_____

Physician_____ **Office Phone**_____**Date of Last Exam**_____

Are you under a physician's care now?	☐ Yes ☐ No	**If yes, please explain:**_____
Have you recently been hospitalized?	☐ Yes ☐ No	**If yes, please explain:**_____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	**Please list drugs:**_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐No	
Do you take any blood thinners?	☐ Yes ☐No	
Do you, or have you, used tobacco products?	☐ Yes ☐No	
Do you use controlled substances?	☐ Yes ☐No	

Women: Are you:

Pregnant/Trying to get pregnant? ☐ Yes ☐ No **Taking oral contraceptives?** ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No

Are you allergic to any of the following?

☐**Aspirin** ☐**Penicillin** ☐**Codeine** ☐**Local Anesthetics** ☐**Acrylic** ☐**Metal** ☐**Latex** ☐**Sulfa drugs**

☐ **Other If yes, please explain:**_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Sexually Transmitted Infection	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Shingles	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sickle Cell Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Sinus Trouble	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Spina Bifida	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stomach/Intestinal Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Swelling of Limbs	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Thyroid Disease	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tonsillitis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tuberculosis	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Tumors or Growths	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Ulcers	Yes	No

Please List any other medical conditions we should be aware of: _____

_____

Patient Dental History

Name of Previous Dentist_____ **Date of Last Exam** _____**Date of Last Cleaning**_____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐	**14. Have you ever had any prolonged bleeding following extractions?**	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	**15. Do you wear dentures or partials?**	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	**If yes, date of placement**_____		
4. Do you feel pain to any of your teeth?	☐	☐	**16. Do you have frequent headaches?**	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐	**17. Do you clench or grind your teeth?**	☐	☐
6. History of any periodontal therapy?	☐	☐	**18. Have you ever experienced any of the following problems in your jaw?**		
7. Do you like your smile?	☐	☐	**Clicking, popping**	☐	☐
8. Do you snore or have you been told that you snore?	☐	☐	**Pain (joint, ear, side of face)**	☐	☐
9. Have you ever received oral hygiene instructions?	☐	☐	**Difficulty in opening or closing**	☐	☐
10. Have you had any head, neck or jaw injuries?	☐	☐	**Difficulty in chewing**	☐	☐
11. Do you bite your lips or cheeks frequently?	☐	☐			
12. Have you ever had any difficult extractions in the past?	☐	☐			
13. Have you had any orthodontic treatment?	☐	☐			

We want to take care of you. If you have any dental anxieties, phobias, or previous bad experiences is there anything we should avoid or take special care with?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my áor patient'sÆ health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____**DATE**_____