PATIENT MEDICAL HISTORY

Patient Name____Date________________
Physician___________________________________Phone__________________________
1) Are you under medical treatment now? Yes_____No_____
If so, please explain____
2) Date of last physical exam____
3) Have you ever had any serious illnesses, operations, or hospitalizations? Yes__No__
If so, please explain____
____
4) Has there been a change in your general health in the past year? Yes___No________
If so, please explain____
5) Do you have or have you had any of the following?

	YES	NO		YES	NO
High blood pressure	_____	_____	Stomach ulcers	_____	_____
Low blood pressure	_____	_____	Colitis	_____	_____
Heart attack	_____	_____	Stroke	_____	_____
Rheumatic fever	_____	_____	Leukemia	_____	_____
Rheumatic heart disease	_____	_____	Lung disease	_____	_____
Congenital heart disease	_____	_____	Asthma	_____	_____
Cardiovascular disease	_____	_____	Emphysema	_____	_____
Heart Murmur	_____	_____	Severe cough	_____	_____
Angina/Chest pain	_____	_____	Chronic cough	_____	_____
Coronary artery disease	_____	_____	Bronchitis	_____	_____
Heart surgery	_____	_____	Pneumonia	_____	_____
Pacemaker	_____	_____	Tuberculosis	_____	_____
Mitral valve prolapse	_____	_____	Shortness of breath	_____	_____
Recent weight loss	_____	_____	Bleeding disorder	_____	_____
Seizures/Convulsions	_____	_____	Bleeding tendency	_____	_____
Epilepsy	_____	_____	Bruise easily	_____	_____
Fainting or dizziness	_____	_____	Anemia	_____	_____
Sinus/nasal problems	_____	_____	Blood transfusion	_____	_____
Hay fever/allergies	_____	_____	Liver Disease	_____	_____
Glaucoma	_____	_____	Hepatitis A	_____	_____
Diabetes	_____	_____	Hepatitis B	_____	_____
Hypoglycemia	_____	_____	Hepatitis C	_____	_____
Kidney disease	_____	_____	Jaundice	_____	_____
Dialysis	_____	_____	Eating disorder	_____	_____
Venereal disease/STDs	_____	_____	Swollen ankles	_____	_____
HIV	_____	_____	Alzheimer’s	_____	_____
AIDS	_____	_____	Mental disorders	_____	_____
Arthritis	_____	_____	Cancer	_____	_____
Any disease/drug/transplant operation that has affected your immune system	_____	_____	Chemotherapy	_____	_____
Implants placed anywhere in your body (heart valve, hip, knee, etc.)	_____	_____	Radiation	_____	_____

6) Are you taking any of the following?

	YES	NO
Antibiotics	____	____
Anticoagulants(blood thinner)	____	____
Aspirin/Motrin/Aleve/Ibuprofen	____	____
High or low blood pressure medications	____	____
Steroids(cortisone,etc.)	____	____
Tranquilizers	____	____
Insulin/oral anti-diabetic medications	____	____
Digitalis/Inderal/Nitroglycerin/heart medications	____	____

Please list all medications that you are taking, including prescription, over-the-counter, birth control pills, herbal or holistic remedies, vitamins or minerals:

____

____

____

____

____

7) Are you allergic to or have you had an adverse reaction to any of the following?

	YES	NO
Local anesthesia(Novocain, etc.)	____	____
Penicillin	____	____
Antibiotics	____	____
Sedatives/barbiturates	____	____
Aspirin/Ibuprofen	____	____
Codeine/pain killers	____	____
Latex/rubber products	____	____
Sulfa drugs	____	____
Iodine	____	____

Others? Please list____

8) For women only

	YES	NO
Are you pregnant or is there any chance that you might be pregnant?	____	____
Are you nursing?	____	____
Are you using contraception?	____	____

If you are using contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle, after the course of antibiotics or other medication is completed. Please consult your physician for further guidance.

9) Do you smoke or chew tobacco? Yes___No___How much perday?________________

10) Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? Yes___No___If so, please explain___________

11) Do you use controlled substances? Yes___No___ If so, please list________________

I understand the importance of a truthful Health History to assist the dentist in providing the best possible care.

__________ ____ ____________

Date Signature of Person Completing Health History Dr.'s Initials

DENTAL HISTORY

Patient name____
Reason for this visit____
Date of your last dental visit____

	YES	NO
Do your gums bleed while brushing or flossing	____	____
Are your teeth sensitive to hot or cold liquids/foods	____	____
Are your teeth sensitive to sweet or sour liquids/foods	____	____
Do you feel pain in any of your teeth	____	____
Do you have any sores or lumps in or near your mouth	____	____
Have you had any head, neck, or jaw injuries	____	____
Do you experience any of the following in your jaw?		
Clicking	____	____
Pain (joint, ear, side of face)	____	____
Difficulty in opening or closing	____	____
Difficulty in chewing	____	____
Do you have frequent headaches	____	____
Do you clench or grind your teeth	____	____
Do you bite your lips or cheeks frequently	____	____
Have you noticed any loosening of your teeth	____	____
Does food tend to become caught between your teeth	____	____
Have you had periodontal treatment(gum treatment)	____	____
Have you ever worn a nightguard or other appliance	____	____
Have you had difficult extractions in the past	____	____
Have you had prolonged bleeding following extractions	____	____
Do you wear dentures or partials	____	____

If so, date of placement____

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

I understand the importance of a truthful Health History to assist the dentist in providing the best care possible.

_______ ____ __________
Date Signature of Person Completing Health History Dr.'s Initials