

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. ARE YOU IN GOOD HEALTH..... | <input type="checkbox"/> | <input type="checkbox"/> | 12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR..... | <input type="checkbox"/> | <input type="checkbox"/> | 13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHTHOSPHONATES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DATE OF YOUR LAST PHYSICAL EXAM: _____ | | | 14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____ | | | 15. DO YOU USE TOBACCO..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN..... | <input type="checkbox"/> | <input type="checkbox"/> | 16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS... PLEASE EXPLAIN. _____ | <input type="checkbox"/> | <input type="checkbox"/> | 17. ARE YOU WEARING CONTACT LENSES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE... IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____ | <input type="checkbox"/> | <input type="checkbox"/> | 18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. HAVE YOU HAD ANY ABNORMAL BLEEDING... | <input type="checkbox"/> | <input type="checkbox"/> | 19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. DO YOU BRUISE EASILY..... | <input type="checkbox"/> | <input type="checkbox"/> | WOMEN ONLY: | | |
| 10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT .. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. HAVE YOU HAD A RECENT WEIGHT LOSS..... | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU NURSING..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | ARE YOU TAKING BIRTH CONTROL PILLS..... | <input type="checkbox"/> | <input type="checkbox"/> |

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO: | | | HIVES OR SKIN RASH..... | <input type="checkbox"/> | <input type="checkbox"/> |
| LOCAL ANESTHETICS LIKE NOVOCAINE..... | <input type="checkbox"/> | <input type="checkbox"/> | FAINING OR DIZZY SPELLS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| PENICILLIN OR OTHER ANTIBIOTICS..... | <input type="checkbox"/> | <input type="checkbox"/> | DIABETES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SULFA DRUGS..... | <input type="checkbox"/> | <input type="checkbox"/> | AIDS OR HIV INFECTION..... | <input type="checkbox"/> | <input type="checkbox"/> |
| BARBITURATES, SEDATIVES OR SLEEPING PILLS... | <input type="checkbox"/> | <input type="checkbox"/> | THYROID PROBLEMS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ASPIRIN..... | <input type="checkbox"/> | <input type="checkbox"/> | ALLERGIES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| IODINE..... | <input type="checkbox"/> | <input type="checkbox"/> | ARTHRITIS OR RHEUMATISM..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ANY METALS (E.G., NICKEL, MERCURY, ETC.)..... | <input type="checkbox"/> | <input type="checkbox"/> | JOINT REPLACEMENT OR IMPLANT..... | <input type="checkbox"/> | <input type="checkbox"/> |
| LATEX / RUBBER..... | <input type="checkbox"/> | <input type="checkbox"/> | STOMACH ULCER..... | <input type="checkbox"/> | <input type="checkbox"/> |
| OTHER (PLEASE LIST) _____ | | | KIDNEY TROUBLE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING: | | | TUBERCULOSIS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER | <input type="checkbox"/> | <input type="checkbox"/> | PERSISTENT COUGH..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SCARLET FEVER..... | <input type="checkbox"/> | <input type="checkbox"/> | COUGH THAT PRODUCES BLOOD..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART DEFECT OR HEART MURMUR..... | <input type="checkbox"/> | <input type="checkbox"/> | CHEMOTHERAPY (CANCER, LEUKEMIA)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART TROUBLE, HEART ATTACK, OR ANGINA..... | <input type="checkbox"/> | <input type="checkbox"/> | SEXUALLY TRANSMITTED DISEASE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| CHEST PAIN..... | <input type="checkbox"/> | <input type="checkbox"/> | EPILEPSY OR SEIZURES..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SHORTNESS OF BREATH..... | <input type="checkbox"/> | <input type="checkbox"/> | ANEMIA..... | <input type="checkbox"/> | <input type="checkbox"/> |
| PACEMAKER..... | <input type="checkbox"/> | <input type="checkbox"/> | GLAUCOMA..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART SURGERY..... | <input type="checkbox"/> | <input type="checkbox"/> | NERVOUSNESS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HIGH/LOW BLOOD PRESSURE..... | <input type="checkbox"/> | <input type="checkbox"/> | TONSILLITIS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| CONGENITAL HEART PROBLEM..... | <input type="checkbox"/> | <input type="checkbox"/> | TUMORS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SWELLING OF FEET, ANKLES, HANDS..... | <input type="checkbox"/> | <input type="checkbox"/> | MENTAL HEALTH CARE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HEPATITIS, JAUNDICE OR LIVER DISEASE..... | <input type="checkbox"/> | <input type="checkbox"/> | BACK PROBLEMS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| STROKE..... | <input type="checkbox"/> | <input type="checkbox"/> | CHEMICAL DEPENDENCY..... | <input type="checkbox"/> | <input type="checkbox"/> |
| SINUS TROUBLE..... | <input type="checkbox"/> | <input type="checkbox"/> | MITRAL VALVE PROLAPSE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| LUNG OR BREATHING PROBLEMS..... | <input type="checkbox"/> | <input type="checkbox"/> | CORTISONE TREATMENT..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ASTHMA OR HAY FEVER..... | <input type="checkbox"/> | <input type="checkbox"/> | COLD SORES/FEVER BLISTERS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | HYPOGLYCEMIA..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | EATING DISORDERS..... | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT'S NUMBER _____

PATIENT'S NAME _____

DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____

WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____

HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

DO YOUR GUMS BLEED WHILE BRUSHING

YES NO

OR FLOSSING

YES NO

ARE YOUR TEETH SENSITIVE TO HOT OR COLD

YES NO

LIQUIDS/FOODS

YES NO

ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR

YES NO

LIQUIDS/FOODS

YES NO

DO YOU FEEL PAIN TO ANY OF YOUR TEETH

YES NO

DO YOU HAVE ANY SORES OR LUMPS IN OR

YES NO

NEAR YOUR MOUTH

YES NO

HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES

YES NO

HAVE YOU EVER EXPERIENCED ANY OF THE

YES NO

FOLLOWING PROBLEMS IN YOUR JAW?

YES NO

CLICKING

YES NO

PAIN (JOINT, EAR, SIDE OF FACE)

YES NO

DIFFICULTY IN OPENING OR CLOSING

YES NO

DIFFICULTY IN CHEWING

YES NO

DO YOU HAVE FREQUENT HEADACHES

YES NO

DO YOU CLENCH OR GRIND YOUR TEETH

YES NO

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

AUTHORIZATION AND RELEASE

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. 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 PRACTITIONERS. I AUTHORIZE AND REQUEST MY

INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE 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 DEPENDENTS.

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR _____
DATE _____

DOCTOR'S COMMENTS _____

SIGNATURE _____

DATE _____

PATIENT'S NUMBER _____