Patient Medical History

Name_____ Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

If yes, what _____

Pharmacy name _____ phone# _____

7. Are you allergic to or had any reactions to the following?

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Barbiturates/Sedatives/Sleeping pills	☐	☐
Latex (Rubber Dams/Gloves)	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

Fill out if applicable:

8. a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) On Birth Control pills?	☐	☐

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

	Yes	No
Tuberculosis	☐	☐
High Blood Pressure	☐	☐
Heart Attact or Angina	☐	☐
Heart Disease/Heart Surgery	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Rheumatic Fever	☐	☐
Joint Replacement or Implant	☐	☐
Do You Take A Pre-Med Before Dental Treatment?	☐	☐
Swollen Ankles	☐	☐
Asthma/Hay Fever	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Trouble/Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Emphysema/Lung Problems	☐	☐
Cancer	☐	☐
Arthritis/Rheumatism	☐	☐
Anemia	☐	☐
Hepatitis	☐	☐
if yes, ☐A, ☐B, ☐C		
Jaundice/Liver Disease	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐
Persistant Cough	☐	☐
Chest Pains	☐	☐
Easily Winded or Tired	☐	☐
Stroke	☐	☐
Hives/Skin Rash	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Scarlet Fever	☐	☐

Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do any of your teeth feel pain?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
☐ Clicking ☐ Pain ☐ Difficulty in opening, closing or chewing		
8. Are you satisfied with the appearance of your teeth?	☐	☐
9. Have you had an upsetting dental experience?	☐	☐
10. Is there anything about having dental treatment that bothers you?	☐	☐
what _____		
11. Do you have frequent headaches?	☐	☐
12. Do you clench or grind your teeth?	☐	☐
13. Do you bite your lips or cheeks frequently?	☐	☐
14. Have you had any difficult extractions in the past?	☐	☐
15. Have you had braces?	☐	☐
16. Have you had any prolonged bleeding following extractions?	☐	☐
17. Have you noticed any loosening of your teeth?	☐	☐
18. Does food get caught between your teeth	☐	☐

Authorization and Release

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that providing incorrect information can be dangerous to my (or patient's) health. **It is my responsibility to inform the dental office of any changes in medical status in the future.**

X _____

(SIGNATURE OF PATIENT, PARENT, or GUARDIAN) (DATE)

MEDICAL HISTORY UPDATE:

DATE	NO CHANGE	COMMENTS	INITIALS: ASST.	DENTIST	HYGIENIST
	☐ N/C				
	☐ N/C				
	☐ N/C				
	☐ N/C				
	☐ N/C				
	☐ N/C				