PATIENT NAME ____________ TODAY'S DATE ____________

HOME ADDRESS ____________ DATE OF BIRTH ____________

____________ HOME PHONE ____________

E-MAIL ____________ CELL PHONE ____________

BUSINESS PHONE ____________

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN ____________ OFFICE PHONE ____________ DATE OF LAST EXAM ____________

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
FOR ____________		
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? ____________		
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐

6. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (E.G. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER ____________
☐	☐	SULFA DRUGS	☐	☐	IODINE			____________

7. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS OR HIV INFECTION	☐	☐	HAY FEVER / ALLERGIES	☐	☐	NERVOUS DISORDERS
☐	☐	ACID REFLUX	☐	☐	HEART ATTACK	☐	☐	RADIATION THERAPY
☐	☐	ANEMIA	☐	☐	HEART DISEASE	☐	☐	RECENT WEIGHT LOSS
☐	☐	ANGINA	☐	☐	HEART MURMUR	☐	☐	RESPIRATORY PROBLEMS
☐	☐	ARTHRITIS	☐	☐	HEART STENTS	☐	☐	RHEUMATIC FEVER
☐	☐	ARTIFICIAL HEART VALVES	☐	☐	HEART TROUBLE	☐	☐	SEXUALLY TRANSMITTED DISEASE
☐	☐	ASTHMA	☐	☐	HEPATITIS / JAUNDICE			
☐	☐	CANCER	☐	☐	HIGH BLOOD PRESSURE	☐	☐	STOMACH TROUBLES / ULCERS
☐	☐	CARDIAC PACEMAKER	☐	☐	HIGH CHOLESTEROL			
☐	☐	CHEMICAL DEPENDENCY	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	STROKE
☐	☐	DIABETES	☐	☐	KIDNEY DISEASES	☐	☐	THYROID PROBLEM
☐	☐	EMPHYSEMA	☐	☐	LIVER DISEASE	☐	☐	TUBERCULOSIS
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	LOW BLOOD PRESSURE	☐	☐	OTHER ____________
☐	☐	FAINTING / SEIZURES	☐	☐	MITRAL VALVE PROLAPSE			____________

COMMENTS

____

____

____

____

SIGNATURE OF DENTIST DATE

PATIENT 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 YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
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?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

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.

X ____________ ____________

PATIENT, PARENT OR GUARDIAN DATE

FORM 020901 N/03/13 ITEM 8101