

PATIENT NAME _____	TODAY'S DATE _____
HOME ADDRESS _____	DATE OF BIRTH _____
_____	HOME PHONE _____
E-MAIL _____	CELL PHONE _____
BUSINESS ADDRESS _____	BUSINESS PHONE _____
_____	SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO		YES	NO	YES	NO	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	<input type="checkbox"/>	<input type="checkbox"/>	8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	<input type="checkbox"/>	<input type="checkbox"/>	YES NO	<input type="checkbox"/>	<input type="checkbox"/>	LOCAL ANESTHETICS (EG. NOVOCAINE)	<input type="checkbox"/>	<input type="checkbox"/>	BARBITURATES
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	SEDATIVES
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____				<input type="checkbox"/>	<input type="checkbox"/>	SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	OTHER
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	<input type="checkbox"/>	<input type="checkbox"/>	9. 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"/>		<input type="checkbox"/>	<input type="checkbox"/>	IODINE
5. DO YOU USE TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>				
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	<input type="checkbox"/>	<input type="checkbox"/>	10. WOMEN ONLY:						
7. ARE YOU WEARING CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>	A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>				
			B) ARE YOU NURSING?	<input type="checkbox"/>	<input type="checkbox"/>				
			C) ARE YOU TAKING BIRTH CONTROL PILLS?	<input type="checkbox"/>	<input type="checkbox"/>				

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

YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE		HEART DISEASE		CHEST PAINS	
HEART ATTACK		CARDIAC PACEMAKER		EASILY WINDED	
RHEUMATIC FEVER		HEART MURMUR		STROKE	
SWOLLEN ANKLES		ANGINA		HAY FEVER / ALLERGIES	
FAINTING / SEIZURES		FREQUENTLY TIRED		TUBERCULOSIS	
ASTHMA		ANEMIA		RADIATION THERAPY	
LOW BLOOD PRESSURE		EMPHYSEMA		GLAUCOMA	
EPILEPSY / CONVULSIONS		CANCER		RECENT WEIGHT LOSS	
LEUKEMIA		ARTHRITIS		LIVER DISEASE	
DIABETES		JOINT REPLACEMENT OR IMPLANT		HEART TROUBLE	
KIDNEY DISEASES		HEPATITIS / JAUNDICE		RESPIRATORY PROBLEMS	
AIDS OR HIV INFECTION		SEXUALLY TRANSMITTED DISEASE		OTHER _____	
THYROID PROBLEM		STOMACH TROUBLES / ULCERS			

COMMENTS

SIGNATURE OF DENTIST _____ DATE _____

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	<input type="checkbox"/>	<input type="checkbox"/>	8. DO YOU HAVE FREQUENT HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU CLENCH OR GRIND YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	<input type="checkbox"/>	<input type="checkbox"/>
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	<input type="checkbox"/>	<input type="checkbox"/>
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU HAD ANY ORTHODONTIC WORK?	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	<input type="checkbox"/>	<input type="checkbox"/>
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
A) CLICKING?	<input type="checkbox"/>	<input type="checkbox"/>	15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	<input type="checkbox"/>	<input type="checkbox"/>
B) PAIN (JOINT, EAR, SIDE OF FACE)?	<input type="checkbox"/>	<input type="checkbox"/>			
C) DIFFICULTY IN OPENING OR CLOSING?	<input type="checkbox"/>	<input type="checkbox"/>			
D) DIFFICULTY IN CHEWING?	<input type="checkbox"/>	<input type="checkbox"/>			

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