

PATIENT MEDICAL & DENTAL HISTORY

PATIENT NAME _____ TODAY'S DATE _____
 STREET & P.O. BOX NUMBER _____ DATE OF BIRTH _____ AGE _____
 CITY _____ STATE _____ ZIP CODE _____
 TELEPHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

MEDICAL HISTORY

NAME AND ADDRESS OF PHYSICIAN _____

1. DATE OF LAST PHYSICAL EXAM _____

2. ARE YOU UNDER MEDICAL TREATMENT NOW? _____

3. WHAT CONDITIONS ARE BEING TREATED? _____

4. LIST ANY CHANGES IN YOUR GENERAL HEALTH THIS PAST YEAR _____

5. LIST ANY SERIOUS ILLNESSES OR OPERATIONS _____

6. HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY OR INJURY?
 EXPLAIN. _____

7. ARE YOU TAKING ANY MEDICATIONS OR DRUGS INCLUDING NON-PRESCRIPTION MEDICINE? IF SO, LIST.

8. HAVE YOU EVER BEEN TREATED FOR: (PLEASE CIRCLE **YES** OR **NO**)

ADDICTION PROBLEMS	Y N	FREQUENTLY TIRED	Y N	LOW BLOOD PRESSURE	Y N
ALLERGIES	Y N	GLAUCOMA	Y N	OSTEOPOROSIS	Y N
ANEMIA	Y N	HEAD INJURY	Y N	PROSTHETIC VALVE	Y N
ANGINA	Y N	HEART ATTACK	Y N	PSYCHIATRIC PROBLEMS	Y N
ARTHRITIS	Y N	HEART DISEASE	Y N	RADIATION THERAPY	Y N
ASTHMA/HAY FEVER	Y N	HEART MURMUR	Y N	RESPIRATORY PROBLEMS	Y N
CANCER	Y N	HEPATITIS/JAUNDICE	Y N	RHEUMATIC HEART DISEASE	Y N
CARDIAC PACEMAKER	Y N	HIGH BLOOD PRESSURE	Y N	SEXUALLY TRANSMITTED DISEASE	Y N
DIABETES	Y N	HIVES / SKIN RASH	Y N	SINUS TROUBLE	Y N
EMPHYSEMA	Y N	IMMUNE SYSTEM DISORDER	Y N	STOMACH TROUBLE/ULCERS	Y N
EPILEPSY/CONVULSIONS	Y N	JOINT REPLACEMENT	Y N	STROKE	Y N
FAINTING/SEIZURES	Y N	KIDNEY DISEASE	Y N	THYROID PROBLEMS	Y N
FRACTURES	Y N	LIVER DISEASE	Y N	TUBERCULOSIS	Y N
				TUMORS	Y N

DO YOU SMOKE OR USE CHEWING PRODUCTS Y N

9. LIST ANY TRAUMATIC EVENTS/STRESSORS THAT HAVE OCCURRED IN YOUR LIFE IN THE PAST YEAR _____

10. LIST ANY ISSUES/CONCERNS REGARDING SOCIAL FUNCTIONING, BEHAVIOR OR SCHOOL/WORK PERFORMANCE _____

11. ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING: (PLEASE CIRCLE ITEM(S) TO WHICH YOU ARE ALLERGIC OR HAVE HAD AN ADVERSE REACTION TO (i.e. Aspirin, Local Anesthetic, etc.)

ASPIRIN

LOCAL ANESTHETICS

BARBITURATES, SEDATIVES, SLEEPING PILLS

LATEX

CODEINES/NARCOTICS

PENICILLIN OR OTHER ANTIBIOTICS

OTHER _____

12. FOR WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? _____

ARE YOU NURSING? _____

ARE YOU TAKING BIRTH CONTROL PILLS? _____

DENTAL HISTORY

1. WHEN WAS YOUR LAST DENTAL VISIT? _____

2. HAVE YOU EVER HAD ANY SERIOUS PROBLEM ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? _____

3. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? _____

4. DO YOUR GUMS FEEL TENDER OR SWOLLEN? _____

5. DO YOU CLENCH YOUR TEETH WHILE SLEEPING OR DURING THE DAY? _____

6. DO YOU WEAR DENTURES? _____

7. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? _____

8. HAVE YOU EVER HAD ANY HEAD, NECK OR JAW INJURIES? _____

9. DO YOU USUALLY HAVE MANY CAVITIES? _____

10. DO YOU LOSE FILLINGS OR BREAK FILLINGS? _____

11. DO YOU REQUIRE MEDICATIONS PRIOR TO ANY DENTAL TREATMENT? IF YES, PLEASE EXPLAIN. _____

12. PLEASE ADD ANYTHING YOU THINK IS IMPORTANT _____

13. REASON FOR THIS VISIT? _____

IN CASE OF AN EMERGENCY PLEASE LET US KNOW THE NAME AND TELEPHONE # OF PERSON TO CONTACT:

NAME _____ TELEPHONE _____

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.

PATIENT, PARENT OR GUARDIAN

DATE

SIGNATURE

PROVIDER SIGNATURE

DATE