Patient Medical History

Physician _____ Office Phone_____Date of Last Exam_____

1. *Are you under medical treatment now?..... yes no*
2. *Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.. yes no*
   If yes, please explain_____
   _____
3. *Are you taking any medication(s) including non-prescription medicine?.....yes no*
   If yes, what medication(s) are you taking?_____
   _____
4. *Have you ever taken Fen-Phen/Redux?..... yes no*
5. *Do you use tobacco?.....yes no*
6. *Do you use controlled substances?.....yes no*
7. *Are you wearing contact lenses?.....yes no*
9. *Are you allergic to or had any reactions to the following?*
   Local Anesthethics (e.g. Novocain)..... yes no
   Penicillin or any other Antibiotics..... yes no
   Sulfa Drugs..... yes no
   Barbiturates..... yes no
   Sedatives..... yes no
   Iodine..... yes no
   Aspirin..... yes no
   Any Metals (e.g. nickel, mercury, etc.)..... yes no
   Latex Rubber..... yes no
   Other (please list)..... yes no
10. *Women Only*
    Are you pregnant or think you may be pregnant? yes no
    Are you nursing?..... yes no
    Are you taking oral contraceptives?..... yes no

8. *Do you have or have you had any of the following?*

High Blood Pressure..... yes no	*Heart Disease..... yes no*	*Chest Pains..... yes no*
Heart Attack..... yes no	*Cardiac Pacemaker..... yes no*	*Easily Winded..... yes no*
Rheumati Fever..... yes no	*Heart Murmur..... yes no*	*Stroke..... yes no*
Swollen Ankles..... yes no	*Angina..... yes no*	*Hay Fever/Allergies..... yes no*
Fainting/Seizures..... yes no	*Frequently Tired..... yes no*	*Tuberculosis..... yes no*
Asthma..... yes no	*Anemia..... yes no*	*Radiation Therapy..... yes no*
Low Blood Pressure..... yes no	*Emphysema..... yes no*	*Glaucoma..... yes no*
Epilepsy/Convulsions..... yes no	*Cancer..... yes no*	*Recent Weight Loss..... yes no*
Leukemia..... yes no	*Arthritis..... yes no*	*Liver Disease..... yes no*
Diabetes..... yes no	*Joint Replacement or Implant... yes no*	*Heart Trouble..... yes no*
Kidney Diseases..... yes no	*Hepatitis/Jaundice..... yes no*	*Respiratory Problems..... yes no*
AIDS or HIV Infection..... yes no	*Sexually Transmitted Disease.... yes no*	*Mitral Valve Prolapse..... yes no*
Thyroid Problem..... yes no	*Stomach Troubles/Ulcers..... yes no*	*Other_____ yes no*

Patient Dental History

Name of Previous Dentist and Location _____Date of Last Exam_____

1. *Do your gums bleed while brushing or flossing?..... yes no*
2. *Are your teeth sensitive to hot or cold liquids/foods?.... yes no*
3. *Are your teeth sensitive to sweet or sour liquids/foods?. yes no*
4. *Do you feel pain to any of your teeth?.....yes no*
5. *Have you had any head, neck or jaw injuries?..... yes no*
6. *Do you clench or grind your teeth?..... yes no*
7. *Have you ever had any difficult extractions in the past?..... yes no*
8. *Have you ever had any prolonged bleeding following extractions?.....yes no*
9. *Do you wear dentures or partials?..... yes no*
   If yes, date of placement_____
10. *Have you ever received oral hygiene instructions regarding the care of your teeth & gums?..... yes no*
11. *Do you like your smile?..... yes no*

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 payors and/or health practioners.

X_____
Signature of patient (or parent/guardian if minor)