PATIENT MEDICAL HISTORY

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 operations or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If YES what medications are you taking? _____		
4.Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine, other drugs	☐	☐
6. Are you wearing contact lenses?	☐	☐
7. Have you ever been pre-medicated with antibiotics for your dental treatment?	☐	☐
8. Are you allergic to or have you had any reactions to the following? e.g.		
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other_____		
9. Women only:		
a) Are you pregnant or do you think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

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

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	**Cardiac Disease**	☐	☐	**Ulcers**	☐	☐
Heart Attack	☐	☐	**Heart Murmur**	☐	☐	**Chest Pains**	☐	☐
Rheumatic Fever	☐	☐	**Hay Fever/Allergies**	☐	☐	**Easily Winded**	☐	☐
Swollen Ankles	☐	☐	**Frequently Tired**	☐	☐	**Stroke**	☐	☐
Fainting/Seizures	☐	☐	**Recent Weight Loss**	☐	☐	**Angina**	☐	☐
Asthma	☐	☐	**Emphysema**	☐	☐	**Tuberculosis**	☐	☐
Low Blood Pressure	☐	☐	**Radiation Therapy**	☐	☐	**Cancer**	☐	☐
STD	☐	☐	**Arthritis**	☐	☐	**Glaucoma**	☐	☐
Leukemia	☐	☐	**Joint Replacement**	☐	☐	**Anemia**	☐	☐
Diabetes	☐	☐	**Joint Implant**	☐	☐	**Liver Disease**	☐	☐
Kidneys	☐	☐	**Hepatitis/Jaundice**	☐	☐	**Heart Trouble**	☐	☐
AIDS or HIV Infection	☐	☐	**Epilepsy/Convulsions**	☐	☐	**Other**_____		
Thyroid Problem	☐	☐	**Stomach Trouble**	☐	☐			
Heart Disease	☐	☐	**Respiratory Problems**	☐	☐			

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids and/or foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids and or foods?	☐	☐
4. Do you feel any pain in your teeth?	☐	☐
5. Do you have any head neck or jaw injuries?	☐	☐
6. 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?	☐	☐
7. Do you clench or grind your teeth?		
8. Do you have frequent headaches?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10. Have you ever had any difficult extractions in the past?	☐	☐
11. Have you had any orthodontic work?	☐	☐
12. Have you ever had any prolonged bleeding following extractions of your teeth?	☐	☐
13. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
14. Have you ever had instruction on the care of your gums ?	☐	☐

15. Date of last dental check-up:_____

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 child's health I authorize the dentist to release any information including the diagnostic and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

Signature of parent/guardian if patient is minor:_____ Date:_____