MEDICAL HISTORY

Patient's name: | Patient's Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have . or medication that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

	Y	N	
Are you under a physician's care?	☐	☐	If yes please explain
Have you ever been hospitalized or had a major operation?	☐	☐	If yes please explain
Have you ever had a serious head or neck injury?	☐	☐	If yes please explain
Are you taking any medications or drugs?	☐	☐	If yes please list
Do you or have you taken , Phen-Fen or Redux?	☐	☐	
Are you on a special diet?	☐	☐	
Do you use tobacco?	☐	☐	
Do you use controlled substances?	☐	☐	

Women-Are You	Y	N		Y	N		Y	N
Pregnant /Trying to get pregnant?	☐	☐	Taking oral contraceptives?	☐	☐	Nursing?	☐	☐

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes,, please explain:

Do you have or have you had any of the following

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive	☐	☐	Cortisone Medication	☐	☐	Hemophilia	☐	☐	Renal Dyalysis	☐	☐
Alzheimer"s Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Rheumatic Fever	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Rheumatism	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Scarlet Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Shingles	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	Hives or Rash	☐	☐	Siclke Cell Disease	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Kidney Problems	☐	☐	Stomach/Intestinal Disease	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Leukemia	☐	☐	Stroke	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Liver Disease	☐	☐	Swelling of Limbs	☐	☐
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Lung Disease	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Pain In Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pace Maker	☐	☐	Radiation Treatments	☐	☐	Yellow Jaundice	☐	☐
Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Recent Weight Loss	☐	☐			

Have you ever had any serious illness not listed above? : ☐ Yes ☐ NoIf Yes, please explain:

DENTAL HISTORY

(Please place a"X" to indicate if you had any of the following.)

		Y	N		Y	N
Reason for todays visit:	Burning sensation on tongue	☐	☐	Mouth breathing	☐	☐
Former Dentist:	Chew on one side of mouth	☐	☐	Mouth pain, brushing	☐	☐
City, State:	Cigarette, pipe,or cigar smoking	☐	☐	Orthodontic treatment (Braces)	☐	☐
Date of last visit:	Bad breath	☐	☐	Pain around ear	☐	☐
Date of last x-rays:	Bleeding Gums	☐	☐	Periodontal treatment (Gums)	☐	☐
How often do you brush?	Blisters on lips or mouth	☐	☐	Sensitivity to cold	☐	☐
How often do you floss?	Clicking or popping jaw	☐	☐	Sensitivity to hot	☐	☐
Who may we thank for referring you:	Dry mouth	☐	☐	Sensitivity to sweets	☐	☐
Additional comments:	Fingernail biting	☐	☐	Sensitivity to biting	☐	☐
	Food collection between teeth	☐	☐	Sores or growths in your mouth	☐	☐
	Foreign objects	☐	☐	Grinding teeth	☐	☐
	Gums swollen or tender	☐	☐	Jaw pain or tiredness	☐	☐
	Lip or cheek biting	☐	☐	Loose teeth or broken fillings	☐	☐

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*