Patient Medical History

Patient Name _____ Sex: ___ M ___ F Birthdate ____/____/_____ Age: _____

Physician/Medical Group _____ Physician Phone #_____

- Date of last physical exam _____ ____ Routine ____ Illness **(PLEASE DESCRIBE ALL YES ANSWERS)**
- Have you been hospitalized in the last 5 years? ____ Yes____ No _____
- Have you had any surgeries in the last 5 years? ____ Yes____ No _____
- Are you undergoing any medical treatment? ____ Yes____ No _____
- Are you presently taking any medications? ____ Yes____ No _____

_____

_____

- Have you ever used a bisphosphonate medication? (Such as: Fosamax, Actonel, Atelvia, Didronel, Boniva) ___ Yes ___ No
- Have you ever had a reaction to any medication? ____ Yes____ No _____

_____

- Are you allergic to: ___ Penicillin ___ Local Anesthetic ___Aspirin ___Latex _____

_____

_____

- Do you bleed abnormally after cuts or extractions? ____ Yes____ No _____
- Have you ever had radiation therapy? ____ Yes____ No _____
- Have you taken steroids (Cortisone) in the past 2 years? ____ Yes____ No _____
- Do you smoke or use smokeless tobacco? How much? ____ Yes____ No _____
- **(WOMEN)** Are you: ____ Pregnant (Due Date ____/____/____) ____ Nursing ____Use birth control _____
- Have you ever had a blood transfusion? ____Yes ____ No If yes, approx. date _____

Check (✔) if you have or have had any of the following:

☐ Anemia	☐ Cough, Persistent	☐ Hepatitis	☐ Rheumatic Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ Herpes I / II	☐ Scarlet Fever
☐ Artificial Heart Valves	☐ Diabetes	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Joints	☐ Epilepsy	☐ HIV / AIDS	☐ Stroke
☐ Asthma	☐ Fainting	☐ Jaw Pain	☐ Swelling of Feet/Ankles
☐ Back Problems	☐ Glaucoma	☐ Kidney Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Liver Disease	☐ Tonsillitis
☐ Cancer	☐ Hearing Problems	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Murmur	☐ Pacemaker	☐ Tumor
☐ Chemotherapy	☐ Heart Problems	☐ Psychiatric Care	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

Please explain any checked responses _____

_____

_____

CHILDREN: ____ uses bottle ____ uses pacifier ____sucks thumb/finger ____has had orthodontic treatment
____ snacks frequently ____ has had poor dental experiences ____ takes a fluoride supplement

Is there anything else we should know about your child?_____

JAW RELATED PROBLEMS: ___difficulty opening/closing mouth ___injury to jaw/head/neck ___jaw/joint noises
___pain in or around ears ___previous treatment for jaw problems or TMJ

(PLEASE COMPLETE BACK OF FORM)

PATIENT DENTAL HISTORY

(PLEASE DESCRIBE ALL YES ANSWERS)

- Date of last dental visit ____/____/____ Reason: _____
- How often do you brush? _____ Floss? _____
- Have you been shown the proper way to brush & floss? ___Yes ___No _____
- Do your gums bleed? When? ___Yes ___No _____
- Have you ever been told you have periodontal (gum) disease? ___Yes ___No _____
- Have you ever been referred for or undergone periodontal surgery? ___Yes ___No _____
- Does food catch between any teeth? Where? ___Yes ___No _____
- Do you experience an unpleasant odor or taste in your mouth? ___Yes ___No _____
- Are your teeth sensitive to: ___hot ___cold ___sweet ___chewing
- Do you clench your teeth? ___Yes ___No _____
- Do you have any removable appliances in/for your mouth?
  ___full denture ___partial denture ___night guard ___retainer ___oral piercings
- What is the main reason for your visit? _____
- Are there any other questions or concerns regarding your overall dental health? _____
  _____
- Do you feel nervous about having dental treatment? ___Yes ___No
  If yes, how may we help you? _____

Date ____/____/____ Signature: _____ _____

Parent/Guardian (relationship to patient _____) Dentist Signature

MEDICAL UPDATES: Please list any changes in health status, medications, hospitalizations, or surgeries:

DATE	CHANGES		PARENT/GUARDIAN SIGNATURE	DENTIST
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____
____/____/____	_____	NONE___	_____	_____