

# PATIENT MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

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 THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH.....	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU BRUISE EASILY.....	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE YOU ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR.....	<input type="checkbox"/>	<input type="checkbox"/>	10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION.....	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			11. HAVE YOU HAD A RECENT WEIGHT LOSS.....	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			12. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX.....	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU UNDER THE CARE OF A PHYSICIAN.....	<input type="checkbox"/>	<input type="checkbox"/>	13. DO YOU USE TOBACCO.....	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN _____	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES.....	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE..... IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	15. ARE YOU WEARING CONTACT LENSES.....	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING.....	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT.....	<input type="checkbox"/>	<input type="checkbox"/>

**WOMEN ONLY:**

ARE YOU PREGNANT OR THINK YOU MAY  
BE PREGNANT.....

ARE YOU NURSING.....

ARE YOU TAKING BIRTH CONTROL PILLS.....

	YES	NO		YES	NO
<b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b>			HIVES OR SKIN RASH.....	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE.....	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZY SPELLS.....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS.....	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION.....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES, OR SLEEPING PILLS...	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN.....	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES.....	<input type="checkbox"/>	<input type="checkbox"/>
IODINE.....	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM.....	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.).....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT.....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER.....	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER.....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</b>			TUBERCULOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER			PERSISTENT COUGH.....	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA).....	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA.....	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES.....	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER.....	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY.....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS.....	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS.....	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS.....	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS.....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE.....	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
STROKE.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY.....	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE.....	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT.....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS.....	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT NUMBER \_\_\_\_\_

# PATIENT MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR THIS VISIT \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT \_\_\_\_\_ WHAT WAS DONE THEN \_\_\_\_\_

HOW OFTEN DID YOU SEE YOUR DENTIST BEFORE THEN \_\_\_\_\_

PREVIOUS DENTIST (NAME AND LOCATION) \_\_\_\_\_

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH \_\_\_\_\_ HOW OFTEN DO YOU FLOSS YOUR TEETH \_\_\_\_\_

IS YOUR DRINKING WATER FLUORINATED \_\_\_\_\_

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY.	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER WORN A BITE PLATE OR APPLIANCE.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES.			HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS WITH YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRATIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE).....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS.....	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE *ANYTHING* ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 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 ACCURATLY 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 PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDANTS.

X \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF PATIENT OR PARENT IF MINOR

DOCTOR'S COMMENTS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT NUMBER \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

### TETTING & TETTING DENTAL CURRENT MEDICATION LIST

Are you taking any prescription medications, over the counter medications, vitamins,  
natural, herbal and/or dietary supplements?

Yes \_\_\_\_\_

No \_\_\_\_\_

Date: \_\_\_\_\_

Please list all medications:

Reason taking:

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