Patient Medical History

Patient Name_____ Sex: M___ F___ Date of Birth___/___/___ Age___

Physician/Medical Group_____ Physician Phone # _____

1. Date of last physical exam_____ _____Routine _____Illness **PLEASE DESCRIBE ALL YES ANSWERS**
2. Have you been hospitalized in the last 5 years? ___yes ___no _____
3. Have you had any surgeries in the last 5 years? ___yes ___no _____
4. Are you undergoing any medical treatment? ___yes ___no _____
5. Are you presently taking any medication? ___yes ___no _____

   _____

   _____
6. Are you currently or have you ever had Bisphosphonate therapy?__yes __no_____
7. Have you ever had a reaction to any medication? ___yes ___no _____

   _____
8. Are you allergic to: ___Penicillin ___Local Anesthetic ___Aspirin ___Latex _____

   _____

   _____
9. Do you bleed abnormally after cuts or extractions? ___yes ___no _____
10. Have you ever had radiation therapy? ___yes ___no _____
11. Have you taken steroids (Cortisone) in the past 2 years? ___yes ___no _____
12. Do you smoke or use smokeless tobacco? How much? ___yes ___no _____
13. (Women) Are you: ___ Pregnant (Due Date___ /___ /_____) ___ Take Birth Control Pills_____
14. Are there any other physical, mental, or emotional problems we should be aware of? ___yes ___no
    If yes, please explain_____
15. Please check if you have ever had any of the following:

___AIDS/HIV	___ Cancer	___Fainting	___ History of Infective Endocarditis	
___Alcohol Addiction	___ Chemotherapy	___Glaucoma	___ Joint Replacement	___Sickle Cell Disease/Trait
___Anemia	___ Chest Pain	___Hearing Problems	___ Kidney Disease	___Stroke
___Arthritis	___ Cold Sores	___ Heart Disease	___ Learning Disabilities	___Tuberculosis
___Artificial Heart Valve	___ Diabetes	___Heart Surgery	___ Liver Disease	___Tumors
___Asthma	___ Drug Addiction	___ Hepatitis A / B / C	___ Osteoporosis	___Thyroid Disease
___Blood Disease	___ Epilepsy	___Herpes I / II	___ Pacemaker	___Venereal Disease
___Bone Disease	___ Emphysema	___ High Blood Pressure	___ Psychiatric Care	
___Congenital Heart Problems/transplant		___ Infectious Diseases		

Please explain any checked responses_____

_____

_____

CHILDREN: ___still uses baby bottle ___uses a pacifier ___sucks thumb/fingers ___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

1. Date of last dental visit ___/ ___/ _____ reason:___________________________
2. How often do you brush? __________________ floss?________________________
3. Have you been shown the proper way to brush and floss? ___yes ___no___________________________
4. Do your gums bleed? When? ___yes ___no___________________________
5. Have you ever been told that you have periodontal (gum) disease? ___yes ___no___________________________
6. Have you ever been referred for or undergone periodontal surgery? ___yes ___no___________________________
7. Does food catch between any teeth? Where? ___yes ___no___________________________
8. Do you experience an unpleasant order or taste in your mouth? ___yes ___no___________________________
9. Are your teeth sensitive to: ___hot ___cold ___sweet ___chewing
10. Do you clench or grind your teeth? ___yes ___no___________________________
11. Do you have any removable appliances in/for your mouth?
    ___full denture ___partial denture ___night guard ___retainer ___ oral piercings
12. What is the main reason for your visit? ____
13. Are there any other questions or concerns regarding your overall dental health? ____________________________
    ____
14. Do you feel nervous about having dental treatment? ___yes ___no
    If yes, how may we help you?____

Date ___/ ___/ ___ SIGNATURE: ____ _________________________

Patient / Guardian (relationship to patient_______________) Dentist Signature

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

DATE	CHANGES		PATIENT/GUARDIAN SIGNATURE	DENTIST
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________
___/ ___/_____	____	none___	______________________________	________