

PATIENT NAME

PATIENT NAME _____

HOME ADDRESS _____

E-MAIL ADDRESS _____

BUSINESS ADDRESS _____

TODAY'S DATE _____

DATE OF BIRTH _____

HOME PHONE _____

CELL PHONE _____

BUSINESS PHONE _____

SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

YES NO

- 1. Are you under medical treatment now? YES NO
- 2. Have you ever been hospitalized for any surgical operation or serious illness? YES NO
- 3. Are you taking any medication(s) including non-prescription medicine? YES NO
If yes, what medication(s) are you taking? _____
- 4. Have you ever taken Fen-Phen/Redux? YES NO
- 5. Do you use tobacco? YES NO
- 6. Do you use alcohol, cocaine or other drugs? YES NO
- 7. Are you wearing contact lenses? YES NO

- 8. Are you allergic to or have you had any reactions to the following?

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> Local anesthetics (eg. novocaine)	<input type="checkbox"/> <input type="checkbox"/> Barbiturates	<input type="checkbox"/> <input type="checkbox"/> Aspirin
<input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics	<input type="checkbox"/> <input type="checkbox"/> Sedatives	<input type="checkbox"/> <input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> <input type="checkbox"/> Iodine	

- 9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? YES NO
- 10. WOMEN ONLY:
 - a) Are you pregnant or think you may be pregnant? YES NO
 - b) Are you nursing? YES NO
 - c) Are you taking birth control pills? YES NO

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

- | | | |
|--|--|---|
| YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Easily Winded |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> <input type="checkbox"/> Angina | <input type="checkbox"/> <input type="checkbox"/> Hay Fever / Allergies |
| <input type="checkbox"/> <input type="checkbox"/> Fainting / Seizures | <input type="checkbox"/> <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> <input type="checkbox"/> Leukemia | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement or Implant | <input type="checkbox"/> <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles / Ulcers | |

COMMENTS

 Signature of Dentist _____ Date _____

PATIENT DENTAL HISTORY

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | YES | NO | | YES | NO |
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you had any orthodontic work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw?
a) Clicking? <input type="checkbox"/> YES <input type="checkbox"/> NO
b) Pain (joint, ear, side of face)? <input type="checkbox"/> YES <input type="checkbox"/> NO
c) Difficulty in opening or closing? <input type="checkbox"/> YES <input type="checkbox"/> NO
d) Difficulty in chewing? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 15. Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |

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 health.

SIGNATURE

X _____

PATIENT, PARENT OR GUARDIAN

DATE