Patient Name: _____ E-Mail: _____
Home Address: _____ Date of Birth: ____/____/_____
Town, Zip: _____ Home Phone: (___)_____
Business Name: _____ Business Tel: (___)_____
Address: _____ Cell Phone: (___)_____

PATIENT MEDICAL HISTORY

Date of Last Exam
Primary Physician: _____ Office Phone: (___)_____ _____/_____/_____
Physician Address: _____ Town: _____ Zip: _____

PLEASE EXPLAIN ALL 'YES' ANSWERS IN SPACE BELOW.

1. Are you under medical treatment now? Yes/No
   Explain _____
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes/No
   Explain _____
3. Do you use tobacco? Yes/No

4. Do you use alcohol, cocaine, other drugs? Yes/No
   List_____
5. Are you wearing contact lenses? Yes/No

_____

6. Are you taking any medication(s) including non-prescription medicine? Yes/No

If yes, what medication(s) are you taking?

_____

_____

_____

_____

_____

_____

_____

_____

7. Are you allergic to, or have you had any reaction to:
   Local Anesthetics (E.g. Novocain) Yes/No
   Sulpha Drugs Yes/No Aspirin Yes/No
   Penicillin or other Antibiotics Yes/No
   List _____
   Anything Else Yes/No
   List _____

8. Do you have or have you had any of the following?
   Please circle or underline

High blood pressure	Angina	Chest pains
Heart attack	Cardiac pacemaker	Easily winded
Heart disease	Rheumatic fever	Diabetes
Heart murmur	Stroke	AIDS or HIV
Heart trouble	Swollen ankles	Anemia
Hay fever/allergies	Emphysema	Cancer
Fainting/seizures	Frequently tired	Tuberculosis
Asthma	Radiation Therapy	Glaucoma
Low blood pressure	Epilepsy/convulsions	Liver disease
Recent weight loss	Stomach trouble/ulcers	Arthritis
Joint replacement full	Joint replacement partial	Leukemia
Kidney diseases	Hepatitis/jaundice	Prostate
Respiratory problems	Osteoporosis	Osteopenia
Thyroid problem	Panic Disorder	Chemotherapy
Sexually transmitted disease	Human Papilloma Virus	
Macular Degeneration	Crohn's Disease	

Other: _____

9. Women Only:
   A. Are you pregnant or think you might be? Yes/No
   B. Are you nursing? Yes/No
   C. Are you taking birth control pills? Yes/No

Specialist's Name(s)	Address	Town, Zip	Telephone
			(____)_____
			(____)_____
			(____)_____

OVER – PLEASE COMPLETE THE REVERSE, ALSO

PATIENT DENTAL HISTORY

10. Do your gums bleed while brushing or flossing? Y/N
11. Are your teeth sensitive to hot or cold liquids/foods? Y/N
12. Are your teeth sensitive to sweet or sour liquids/foods? Y/N
13. Do you feel pain in any of your teeth? Y/N
14. Do you have any sores or lumps in or near your mouth? Y/N
15. Have you had any head, neck or jaw injuries? Y/N
16. Have you ever experienced any of the following problems in your jaw?
    - A. Clicking? Y/N
    - B. Pain (joint, ear, side of face)? Y/N
    - C. Difficulty in opening or closing? Y/N
    - D. Difficulty in chewing? Y/N

Date of last dental visit _____/_____/_____

17. Do you have frequent headaches? Y/N
18. Do you clench or grind your teeth? Y/N
19. Do you bite your lips or cheeks frequently? Y/N
20. Have you ever had any difficult extractions? Y/N
21. Have you ever had any orthodontic work? Y/N
22. Have you ever had prolonged bleeding following extractions? Y/N
23. Have you ever had instruction on the correct method of brushing your teeth? Y/N
24. Have you ever had instruction on the care of your gums? Y/N
25. Do you get cold sores? Y/N
26. **Permission to take x-rays?** **Y/N**

SIGNATURE

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.

X _____ _____/_____/_____
Patient, Parent or Guardian Date

Changes in Line # _____

_____

Signature: _____ Date: _____/_____/_____
Patient, Parent or Guardian

Changes in Line # _____

_____

Signature: _____ Date: _____/_____/_____
Patient, Parent or Guardian

Changes in Line # _____

_____

Signature: _____ Date: _____/_____/_____
Patient, Parent or Guardian

Changes in Line # _____

_____

Signature: _____ Date: _____/_____/_____
Patient, Parent or Guardian

Changes in Line # _____

_____

Signature: _____ Date: _____/_____/_____
Patient, Parent or Guardian

OVER – PLEASE COMPLETE THE REVERSE, ALSO