

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now? Yes  No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes  No   
If yes, please explain \_\_\_\_\_
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. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes  No
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes  No
7. Do you use tobacco? Yes  No
8. Do you use controlled substances? Yes  No
9. Do you have or have you had any of the following? Yes  No

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|------------------------|------------------------------|-----------------------------|
| High Blood Pressure    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Attack           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rheumatic Fever        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Swollen Ankles         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fainting / Seizures    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Low Blood Pressure     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Epilepsy / Convulsions | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Leukemia               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Kidney Diseases        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| AIDS or HIV Infection  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Thyroid Problem        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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|------------------------------|------------------------------|-----------------------------|
| Heart Disease                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cardiac Pacemaker            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Murmur                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Angina                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Frequently Tired             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Anemia                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Emphysema                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cancer                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Arthritis                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Joint Replacement or Implant | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Hepatitis / Jaundice         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sexually Transmitted Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stomach Troubles / Ulcers    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Do your gums bleed while brushing or flossing? Yes  No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes  No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes  No
4. Do you feel pain to any of your teeth? Yes  No
5. Do you have any sores or lumps in or near your mouth? Yes  No
6. Have you had any head, neck or jaw injuries? Yes  No
7. Have you ever experienced any of the following problems in your jaw? Yes  No

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|----------------------------------|------------------------------|-----------------------------|
| Clicking                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pain (joint, ear, side of face)  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Difficulty in opening or closing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Difficulty in chewing            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

8. Do you have frequent headaches? Yes  No
9. Do you clench or grind your teeth? Yes  No
10. Do you bite your lips or cheeks frequently? Yes  No
11. Have you ever had any difficult extractions in the past? Yes  No
12. Have you ever had any prolonged bleeding following extractions? Yes  No
13. Have you had any orthodontic treatment? Yes  No
14. Do you wear dentures or partials? Yes  No   
If yes, date of placement \_\_\_\_\_
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes  No
16. Do you like your smile? Yes  No

# 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 accurately 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 authorize 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 dependents.

**X** Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments _____	Signature _____	Date _____
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