PATIENT MEDICAL HISTORY

Patient Name:____ Birthday: ______________

Please list all medications you are currently taking, including "over the counter" and Herbal supplements:

____

____

Please list the name and phone number of all the physicians who are currently treating you: ______________

____

____

Are you allergic to or have you had any reactions to any of the following:	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Latex	☐	☐
Codeine	☐	☐
Any Other? ____________________		
____________________________		
Do you have cancer?	☐	☐
Have you ever had cancer?	☐	☐
When and what kind? ____________		
____________________________		
Do you have AIDS or HIV?	☐	☐
Do you have Hepatitis/Jaundice?	☐	☐
Have you had a joint replaced?	☐	☐
Do you have tuberculosis?	☐	☐
Do you have a thyroid problem?	☐	☐
Have you ever had a stroke?	☐	☐

	Yes	No
Have you ever taken Fen-Phen/Redux?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Do you bleed easily?	☐	☐
Are you Pregnant?	☐	☐
Are you taking Birth Control Pills?	☐	☐
Do you have Diabetes?	☐	☐
Do you have asthma?	☐	☐
Have you ever had Rheumatic Fever?	☐	☐
Do you have a Heart murmur?	☐	☐
Have you ever had a Heart attack?	☐	☐
Do you have a pacemaker?	☐	☐
Do you have high blood pressure?	☐	☐
Do you have Mitral Valve Prolapse?	☐	☐
Do you have a Liver disease?	☐	☐
Do you have a Kidney disease?	☐	☐
Are you Epileptic or have Convulsions?	☐	☐
Do you have any Respiratory problems?	☐	☐

PATIENT DENTAL HISTORY

Do your gums bleed while brushing?	☐	☐
Do you feel any pain in your teeth?	☐	☐
Have you had orthodontic treatment?	☐	☐
Do you have any popping in your jaws?	☐	☐
Are your teeth sensitive to hot/cold?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have frequent headaches?	☐	☐
Do you like your smile?	☐	☐

Name of previous Dentist: ____

Date of last Exam, cleaning, and x-rays: _____________________________________

Is there anything you did not like about your previous Dentist? ___________________________

What can we do to exceed your expectations? _________________________________

____

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 or insufficient 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 other health providers.

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Signature of patient (or parent/guardian if minor) and Date