Patient Name_____________________________ **Today's Date**__________________

PATIENT MEDICAL HISTORY

Physician ________________________________ Office Phone__________________ Date of Last Exam_______________

	Question	Yes	No
1.	Are you Under Medical Treatment Now	☐	☐
2.	Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3.	Are you taking any medication(s) Including non-prescription medicine? If yes, what medication(s) are you taking? ____________________	☐	☐
4.	Have you ever taken Fen-Phen/Redux?	☐	☐
5.	Do you use tobacco?	☐	☐
6.	Do you use alcohol, cocaine or other drugs?	☐	☐
7.	Are you wearing contact lenses?	☐	☐
8.	Are you allergic to or have you had any reactions to the following?	☐	☐
	Local Anesthetics	☐	☐
	Penicillin or other Antibiotics	☐	☐
	Sulfa Drugs	☐	☐
	Barbiturates	☐	☐
	Sedatives	☐	☐
	Iodine	☐	☐
	Aspirin	☐	☐
	Other_________	☐	☐
9.	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 wks)?	☐	☐
10.	Women ONLY:		
	a. Are you pregnant or think you may be pregnant?	☐	☐
	b. Are you nursing?	☐	☐
	c. Are you taking birth control pills?	☐	☐

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

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies
☐	☐	Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other____________
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	_________________

PATIENT DENTAL HISTORY

Dentist ________________________________ Office Phone____________________ Date of Last Exam_________________

	Question	Yes	No
1.	Do your gums bleed while brushing or flossing?	☐	☐
2.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.	Do you feel pain to any of your teeth?	☐	☐
5.	Do you have any sores or lumps in or near your mouth?	☐	☐
6.	Have you had any head, neck or jaw injuries?	☐	☐
7.	Have you ever experienced any of the following Problems in your jaw?		
	A) Clicking	☐	☐
	B) Pain (joint, ear, side of face)?	☐	☐
	C) Difficulty in opening or closing?	☐	☐
	D) Difficulty in chewing?	☐	☐
8.	Do you have frequent headaches?	☐	☐
9.	Do you clench or grind your teeth?	☐	☐
10.	Do you bite your lips or cheeks frequently?	☐	☐
11.	Have you ever had any difficult extractions In the past?	☐	☐
12.	Have you had any orthodontic work?	☐	☐
13.	Have you ever had prolonged bleeding Following extractions?	☐	☐
14.	Have you ever had instruction on the Correct method of brushing your teeth?	☐	☐
15.	Have you ever had instructions on the Care of your gums?	☐	☐

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**