Patient Medical History

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Medical Dr. Name _____ Date of Last Medical Exam _____

	Yes	No
1. Have you ever been hospitalized for a surgical operation or serious illness?	☐	☐
2. Are you taking medication(s) including non-prescription medicine? If yes, see below to list meds.	☐	☐
3. Please Circle if you consume/use Alcohol, Marijuana, Cocaine, ...etc.		
5. Are you wearing contact lenses?	☐	☐
6. Do you have a persisitent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐

email address:

7. Are you allergic to or have you had any reactions to the following?
Please circle:
Local Anesthetics, Penicillin, Sulfa Drugs, Sedatives, Codeine, Aspirin
Other: _____

8. Women only:	Yes	No
A) Are you pregnant or think you may be pregnant?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking birth control?	☐	☐

9. Do you experience or have you had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Asthma	☐	☐	Anemia	☐	☐	Hepatitis/Jaundice
☐	☐	Heart Attack/Chest Pains	☐	☐	Emphysema	☐	☐	Arthritis	☐	☐	Kidney Disease
☐	☐	Angina	☐	☐	Respiratory Problems	☐	☐	Artificial Joint Replacement	☐	☐	Leukemia
☐	☐	Heart Murmur	☐	☐	Hay Fever/Allergies	☐	☐	Diabetes	☐	☐	Liver Disease
☐	☐	Cardiac Pacemaker	☐	☐	Rheumatic Fever	☐	☐	Epilepsy/Convulsions	☐	☐	Stomach Problems/Ulcer
☐	☐	Heart Disease/Stent	☐	☐	Snoring	☐	☐	Fainting/Seizures	☐	☐	Thyroid Problem
☐	☐	Stroke	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	Tuberculosis
☐	☐	Low Blood Pressure	☐	☐	Radiation /Chemotherapy				☐	☐	Other_____
☐	☐	Swollen Ankles	☐	☐	AIDS or HIV Infection						
			☐	☐	Sexually Transmitted Disease						

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensititve to cold liquids / foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids / foods?	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Have you ever experienced any of the following problems in your jaw?	☐	☐
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10. Have you had any orthodontic work?	☐	☐

Clicking? ☐ Pain (joint, ear, side of face)? ☐ Difficulty in opening or closing? ☐ Difficulty in chewing? ☐

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.

Patient, Parent or Guardian Signature | Patient Printed Name | Date

CURRENT MEDICATION	REASON

Office Staff Only

Date	Change	Initials