Patient Medical History

Physician_____ Office phone_____ Date of Last Exam_____

1.Are you under medical treatment now?

2.Have you been hospitalized for any surgical operation or serious illness within the last five years? y n

If yes, please explain_____ y n

3.Are you taking any medications including non- prescription medicines? y n

If yes, please list_____

4.Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing biphosphanates? y n

5.Have you taken Viagra, Revatio, Cialis, or Levitra? y n

6.Do you use smokeless tobacco? y n

7.Do you smoke cigarettes or cigars? y n

8.Do you use controlled substances? y n

9.Are you wearing contact lenses? y n

10.Are you allergic to or have you had any reactions to the following?

local anesthesia	y	n	sulfa drugs	y	n	other	y	n
penicillin	y	n	barbiturates	y	n	iodine	y	n
other antibiotics	y	n	Any metals-e.g.nickel, mercury,etc	y	n	aspirin	y	n
latex rubber	y	n	sedatives	y	n	acrylic	y	n

11.Women only-are you:

Pregnant or think you may be pregnant? y n

Nursing? y n

Taking oral contraceptives? y n

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

High blood pressure	y	n	heart disease	y	n	chest pains	y	n
heart attack	y	n	cardiac pacemaker	y	n	stroke	y	n
rheumatic fever	y	n	angina	y	n	hay fever/ allergies	y	n
fainting/seizure	y	n	eating disorder	y	n	tuberculosis	y	n
asthma	y	n	anemia	y	n	radiation therapy	y	n
low blood pressure	y	n	emphysema	y	n	glaucoma	y	n
epilepsy/ convulsions	y	n	cancer	y	n	organ transplant	y	n
leukemia	y	n	arthritis	y	n	liver disease	y	n
diabetes	y	n	joint replacement/implant	y	n	heart valve transplant	y	n
kidney disease	y	n	sexually transmitted disesase/hpv	y	n	mitral valve prolapse	y	n
aids/ hiv infection	y	n	ulcers/ stomach troubles	y	n	blood disorder	y	n
thyroid problem	y	n	hepatitis/type	y	n	blood thinner	y	n

Have you ever had any serious illness not listed above? y n

If yes, please explain _____

Name of Previous Dentist/Location _____ date of last exam_____

1.Do your gums bleed while brushing or flossing? y n

2.Are your teeth sensitive to hot or cold liquids/ foods? y n

3.Are your teeth sensitive to sweet or sour liquids/ foods? y n

4.Do you feel pain in any of your teeth? y n

5.Do you have any sores or lumps in your mouth? y n

6.Have you had any head, neck, or jaw injuries? y n

7.Have you experienced any of the following with your jaw?

- clicking y n
- pain (joint, ear, side of face) y n
- difficulty opening/ closing y n
- difficulty chewing y n

8.Do you clench or grind your teeth? y n

9.Do you bite your lips or cheeks frequently? y n

10.Do you have frequent headaches? y n

11.Have you ever had any difficult extractions in the past? y n

12. Have you ever had prolonged bleeding after extractions? y n

13.Have you had any orthodontic treatment? y n

14.Do you wear dentures/ partials? y n

If yes, date of placement

15.Have you ever received oral hygiene instruction regarding care of teeth and gums? y n

16. Do you like your smile? y n

I CERTIFY I HAVE READ THE ABOVE INFORMATION. I HAVE ANSWERED ALL OF THE QUESTIONS ACCURATELY AND REALIZE PROVIDING INCORRECT INFORMATION CAN ENDANGER MY HEALTH.

PRINT_____ SIGNATURE/ DATE_____ DR. REVIEWED_____