PATIENT MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

Although we primarily treat the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving.

Reason for your visit today _____
When was your last dental visit? _____
What was done then? _____
How often did you visit the dentist before then? _____
Name of previous dentist_____
Address / Phone # _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
Are you in good health?_____
Have there been any changes in your general health within the past year? _____
Date of your last physical exam: _____
Physician's name_____
Address / Phone # _____
Are you under the care of a physician now? _____
Have you ever been hospitalized for any surgical operation or serious illness? If yes please explain. _____
_____
Have you ever been told you need to Pre-Medicate prior to having dental treatment? _____
Do you bruise easily? _____
Have you ever required a blood transfusion? _____
Do you use tobacco? _____
Do you or have you used controlled substances? _____
Have you ever taken Fen-Phen or Redux? _____
Have you ever taken any drug to prevent osteoporosis such as Fosamax, Actamel, Boniva, or Reclast? _____
Do you have any disease, condition or problem not listed that you think we should know about?_____
_____

Yes/No Do your gums bleed while brushing or flossing?
Yes/No Are your teeth sensitive to HOT COLD SWEET SOUR?
Yes/No Do you feel any pain in your teeth?
Yes/No Do you have any sores or lumps in or near your mouth?
Yes/No Do you bite your lips or cheeks frequently?
Yes/No Does food get caught between your teeth?
Yes/No Do you have frequent headaches?
Yes/No Do you clench or grind your teeth?
Yes/No Have you had any head, neck or jaw injuries?
Yes/No Have you had any of the following jaw problems --- pain, clicking, difficulty chewing or opening / closing?
Yes/No Do you get heartburn or acid reflux on a regular basis?
Yes/No Have you ever received oral hygiene instructions?
Yes/No Have you ever had Periodontal (Gum) treatment?
Yes/No Have you noticed any loosening of your teeth?
Yes/No Have you ever had any abnormal bleeding?
Yes/No Have you had any difficult extractions in the past?
Yes/No Have you had prolonged bleeding after an extraction?
Yes/No Are you difficult to anesthetize (numb)?
Yes/No Have you ever worn a bite plate or other appliance?
Yes/No Do you wear dentures or partials?
If yes, date of placement _____

If you could change ANYTHING about your smile, what would you change _____
_____

Women Only:

Yes/No --- Are you taking birth control pills?
Yes/No --- Are you pregnant or think you may be pregnant?
If yes -- due date _____
Yes/No --- Are you nursing?

I certify that I have read and understand this health questionnaire. The questions have been answered accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

_____ Date_____
Signature of Patient, or Parent/ Guardian if a minor

Dentist's Comments_____
_____
_____

Signature_____ Date _____

OVER PLEASE →

Are you allergic to or have you had a reaction to: **Circle all that apply**

Amoxicillin
Ampicillin
Aspirin
Augmentin
Benadryl
Cephalexin
Cephalosporin
Cipro
Cleocin
Clindamycin
Codeine
Demerol
Erythromycin
Ibuprofen / Motrin
Keflex
Latex / Rubber
Lortab
Metals (Nickel, Mercury, etc.)
Morphine
Novocaine
Penicillin
Percocet
Sensitive to Epinephrine
Steroids
Sulfa Drugs
Tetracycline
Tylenol
Valium
Vicodin
Zithromax
Zomax
Zylocaine
Other_____
None

Do you or have you ever had the following: **Circle all that apply**

Allergies
Anemic
Arthritis / Rheumatism
Artificial Joint(s) / Valve
Asthma
Autism
Back problems
CAD
Cancer, Leukemia
Chemical / Alcohol Dependency
Chest pain / Angina
Cold sores / Fever blisters
Colitis
COPD
Cortisone Treatment
Diabetes Type I or II
Eating Disorder
Epilepsy / Seizures
Emphysema
Fainting / Dizzy Spells
Fibromyalgia
Gastric Bypass
Glaucoma
Heart Attack
Heart Defect / Heart Murmur
Heart Surgery
Hepatitis -- A – B – C
High Blood Pressure
HIV Infection / AIDS
Hypoglycemia
Kidney Trouble
Liver Disease
Low Blood Pressure
Lung / Breathing problems
Meningitis
Mental Health Care
Mitral Valve Prolapse
Mono
MS
Nervousness
Pacemaker
Rheumatic Fever / Rheumatic Heart Disease
Scarlet Fever
Sexually Transmitted Disease (STD)
Shortness of breath
Sinus Trouble
Sleep Apnea
Stroke / Mini Stroke
Swelling of Feet, Ankles, Hands
Thyroid Problems
Transplant
Tuberculosis / Chronic Cough
Ulcers
Other _____
None

Are you currently taking any of the following: **Circle all that apply**

Antibiotic
Anti-Depressants
Aspirin
Actamel
Beta Blocker
Boniva
Carvedilol
Coumadin
Diabetes Medication
Dilantin
Flovent
Fosamax
Furosemide
Herbal Medicines
High Blood Pressure Medication
Omeprazole
Phena Barbutal
Plavix
Pradaxa
Psychiatric Drugs
Prednisone
Reclast
Remicaid
Simvastatin
Warfarin
None

List other medicine(s), including non-prescription, you are taking: _____

_____