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Patient Medical History

Patient Name: _____ **Date of Birth:** ___/___/_____ Age: _____

LAST FIRST

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness? If yes, please explain: _____	☐	☐

	Yes	No
Do you use tobacco in any form?	☐	☐
(WOMEN) Are you Pregnant?	☐	☐
(WOMEN) Are you Nursing?	☐	☐

ALLERGIES

Are you allergic to or have had any reactions to the following:

	Yes	No		Yes	No
Local Anesthetics	☐	☐	Codeine	☐	☐
Pencillin	☐	☐	Percocet	☐	☐
Sulfa Drugs	☐	☐	Latex Rubber	☐	☐
Barbiturates	☐	☐	Any Metals	☐	☐
Sedatives	☐	☐	Other: _____		
Aspirin	☐	☐			

CURRENT MEDICATIONS Please list below:

_____

_____

_____

Do you have, or have you had, any of the following?

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Asthma	☐	☐
Rheumatic Fever	☐	☐	Leukemia	☐	☐
Fainting/Seizures	☐	☐	Diabetes	☐	☐
Heart Disease	☐	☐	AIDS/HIV+	☐	☐
Low Blood Pressure	☐	☐	Anemia	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐
Kidney Disease	☐	☐	Cold Sores	☐	☐
Thyroid Problem	☐	☐	Arthritis	☐	☐
Cardiac Pacemaker	☐	☐	Stroke	☐	☐
Heart Murmur	☐	☐	Glaucoma	☐	☐
Emphysema	☐	☐	Mitral Valve Prolapse	☐	☐
Joint Replacement	☐	☐	Liver Disease	☐	☐
Hepatitis/Jaundice	☐	☐			
Sexually Transmitted Disease	☐	☐			
Stomach Troubles / Ulcers	☐	☐			
Sinus Trouble	☐	☐			
Respiratory Problems	☐	☐			
Hay Fever/Allergies	☐	☐			
Tuberculosis	☐	☐			
Radiation Therapy	☐	☐			
Recent Weight Loss	☐	☐			
Congenital Heart Problem	☐	☐			

Other: _____

_____

Patient Dental History

Name of Previous Dentist and Location: _____ When was your last dental visit and X-rays? _____

Have you ever pre-medicated before dental treatment? ☐ Yes ☐ No If yes, please explain: _____

Do you have any of the following?

	Yes	No		Yes	No		Yes	No
Bleeding gums	☐	☐	Loose teeth	☐	☐	Dentures or partials	☐	☐
Sensitivity to hot/cold	☐	☐	Sensitivity to sweets	☐	☐	Swelling in the mouth	☐	☐
Sensitivity to pressure	☐	☐	Bite your cheeks or lips	☐	☐	Difficult extractions	☐	☐
Sores or lumps in or near your mouth	☐	☐	Clenching or grinding	☐	☐	Bad breath	☐	☐
			Orthodontic treatment	☐	☐	Change in your bite	☐	☐
Clicking or popping in the jaw	☐	☐	Pain in your jaw	☐	☐	Difficulty opening or closing your jaw	☐	☐

Rate your smile from 1-10 (1=dissatisfied, 10=happy): _____

What aspect of your smile would you most like to correct: _____

Has anything prevented you from addressing this concern in the past: _____

Does dental treatment make you nevous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had your teeth whitened in the past, including over the counter products? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, the questions on this form have been acurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my health status.

_____ _____

Signature of patient, parent or legal guardian Date