

PATIENT NAME _____
HOME ADDRESS _____

E-MAIL _____
EMPLOYER _____
INSURANCE CO. _____

TODAY'S DATE _____
DATE OF BIRTH _____
HOME PHONE _____
CELL PHONE _____
BUSINESS PHONE _____
SSN/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ **OFFICE PHONE** _____ **DATE OF LAST EXAM** _____

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 the reactions to the following?
 YES NO YES NO YES NO
 Local Anesthetics (eg. novocaine) Sulfa Drugs Iodine
 Penicillin or other antibiotics Nitrates Other _____

9. **WOMEN ONLY** YES NO
 (a) Are you pregnant or think you may be pregnant?
 (b) Are you nursing?
 (c) Are you taking birth control pills?

10. Do you have a persistent cough or throat clearing not associated with a known illness lasting more than 3 weeks?

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

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Early-Window
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Swollen Ankle	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Hay Fever / Allergies
<input type="checkbox"/> <input type="checkbox"/> Fainting / Seizure	<input type="checkbox"/> <input type="checkbox"/> Frequently tired	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> <input type="checkbox"/> Low/High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Glaucoma
<input type="checkbox"/> <input type="checkbox"/> Epilepsy / Convulsions	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> <input type="checkbox"/> Gout/Gonorrhea	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Liver Disease
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Joint Replacement or Implant	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice	<input type="checkbox"/> <input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Infection	<input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> <input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> <input type="checkbox"/> Stomach Trouble/Digestion	

COMMENTS

Physician Initials _____ Date _____

PATIENT DENTAL HISTORY

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 treatment?

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?

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered and that no pertinent information has been disregarded or withheld.

SIGNATURE X _____