Patient Medical History Date: _____

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

Are you taking any medication, including non-prescription medicine? Yes □ No □
If yes, list the medications here: _____

Have you been hospitalized for any surgical operation or serious illness in the last 5 years: Yes □ No □
If yes, explain: _____

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

Local Anesthetics (e.g. Novocain)	Yes □ No □	Sedatives	Yes □ No □
Penicillin or other antibiotics	Yes □ No □	Iodine	Yes □ No □
Sulfa Drugs	Yes □ No □	Aspirin	Yes □ No □
Barbiturates	Yes □ No □	Latex Rubber	Yes □ No □
Any Metals (nickel, mercury, etc)	Yes □ No □	Other_____	Yes □ No □

Do you use tobacco? Yes □ No □
Do you use controlled substances? Yes □ No □ Do you wear contacts? Yes □ No □

Women: Are you pregnant or do you think you are pregnant? Yes □ No □
Are you taking oral contraceptives? Yes □ No □
Are you nursing? Yes □ No □

Please circle any of the following conditions that you have, or have had in the past:

High Blood Pressure	Chest Pains	Joint Replacement /Implant	Thyroid Problem
Low Blood Pressure	Heart Murmur	Emphysema	Anemia
Heart Trouble	Mitral Valve Prolapse	Cancer	Arthritis
Heart Disease	Easily Winded	Leukemia	Glaucoma
Stroke	Hay Fever/Allergies	Radiation Therapy	Tuberculosis
Heart Attack	Asthma	Kidney Disease	Epilepsy/Convulsions
Cardiac Pace Maker	Respiratory Problems	Liver Disease	Swollen Ankles
Angina	Rheumatic Fever	Diabetes	Stomach Troubles/Ulcers
Fainting/Seizures	Hemophilia	Hepatitis/Jaundice	Recent Weight Loss
Persistent Diarrhea	Frequently Tired	Recurrent Fevers	Chills/Night Sweats
S. T. D.	AIDS or HIV	Other:_____	

Dental History

NAME OF PREVIOUS DENTIST: _____ **DATE OF LAST EXAM:** _____

Do your gums bleed while brushing/flossing?	Yes □ No □	Do you have frequent headaches?	Yes □ No □
Are your teeth sensitive to hot or cold?	Yes □ No □	Do you clench or grind your teeth?	Yes □ No □
Are your teeth sensitive to sweet or sour?	Yes □ No □	Do you bite your lips or cheeks?	Yes □ No □
Have you injured your head, neck, or jaw?	Yes □ No □	Have you had orthodontic treatment?	Yes □ No □
Do you wear dentures or partials?	Yes □ No □	Placement date: _____	

Do you have any sores or lumps near or around your mouth? Yes □ No □
Have you ever had any prolonged bleeding following extractions? Yes □ No □
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes □ No □
Have you ever experienced any of the problems with your jaw? Please circle all that apply.
Clicking Pain (joint, ear, side of face) Difficulty opening or closing Difficulty chewing

Do you like your smile ☺ ? Yes □ No □ If no, explain: _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

_____
Patient Signature or Responsible Party Signature if patient is a minor Date