

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____
HOME ADDRESS _____ DATE OF BIRTH _____
_____ HOME PHONE _____
BUSINESS ADDRESS _____ BUSINESS PHONE _____
_____ SOC. SEC. NO. _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW? | <input type="checkbox"/> | <input type="checkbox"/> | 7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY. | | |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 4. DO YOU USE TOBACCO? | <input type="checkbox"/> | <input type="checkbox"/> | 8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? | | |
| 5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 6. ARE YOU WEARING CONTACT LENSES? | <input type="checkbox"/> | <input type="checkbox"/> | 9. WOMEN ONLY: | | |
| | | | A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | B) ARE YOU NURSING? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | C) ARE YOU TAKING BIRTH CONTROL PILLS? | <input type="checkbox"/> | <input type="checkbox"/> |

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.
- | | | | |
|---|---|--|---|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> CHEST PAINS | <input type="checkbox"/> KIDNEY DISEASES |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> CARDIAC PACEMAKER | <input type="checkbox"/> EASILY WINDED | <input type="checkbox"/> AIDS OR HIV INFECTION |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> STROKE | <input type="checkbox"/> THYROID PROBLEM |
| <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> ANGINA | <input type="checkbox"/> HAY FEVER / ALLERGIES | <input type="checkbox"/> HEPATITIS / JAUNDICE |
| <input type="checkbox"/> FAINTING / SEIZURES | <input type="checkbox"/> FREQUENTLY TIRED | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> RADIATION THERAPY | <input type="checkbox"/> STOMACH TROUBLES / ULCERS |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> CANCER | <input type="checkbox"/> RECENT WEIGHT LOSS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> LIVER DISEASE | _____ |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT | <input type="checkbox"/> HEART TROUBLE | _____ |

COMMENTS

PATIENT DENTAL HISTORY

- PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.
- | | | | |
|---|--------------------------|---|--------------------------|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? | <input type="checkbox"/> | 8. DO YOU HAVE FREQUENT HEADACHES? | <input type="checkbox"/> |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? | <input type="checkbox"/> | 9. DO YOU CLENCH OR GRIND YOUR TEETH? | <input type="checkbox"/> |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? | <input type="checkbox"/> | 10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? | <input type="checkbox"/> |
| 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? | <input type="checkbox"/> | 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? | <input type="checkbox"/> |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? | <input type="checkbox"/> | 12. HAVE YOU HAD ANY ORTHODONTIC WORK? | <input type="checkbox"/> |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? | <input type="checkbox"/> | 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? | <input type="checkbox"/> |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? | | 14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? | <input type="checkbox"/> |
| A) CLICKING? | <input type="checkbox"/> | 15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? | <input type="checkbox"/> |
| B) PAIN (JOINT, EAR, SIDE OF FACE)? | <input type="checkbox"/> | | |
| C) DIFFICULTY IN OPENING OR CLOSING? | <input type="checkbox"/> | | |
| D) DIFFICULTY IN CHEWING? | <input type="checkbox"/> | | |

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

X _____ DATE _____
PATIENT, PARENT OR GUARDIAN