Patient Medical History

Name (patient) _____ Date _____
First M Last

Medical Physician _____ Office Phone _____ Last Exam _____

Medical Specialist _____

Favorite Pharmacy _____ Phone # _____

Pharmacy Address _____ City _____

	YES	NO	Not Sure
1. Are you under medical treatment now	☐	☐	☐
2. Have you ever been hospitalized	☐	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐	☐
If yes, what medication(s) are you taking?			
_____			
_____			
4. Do you use tobacco?	☐	☐	☐
5. Do you consume alcohol?	☐	☐	☐
6. Do you wear contact lenses?	☐	☐	☐

7. Are you allergic to or have you had any reactions to the following:	YES	NO	Not Sure
Aspirin	☐	☐	☐
Barbiturates	☐	☐	☐
Codeine	☐	☐	☐
Iodine	☐	☐	☐
Local anesthetics (i.e. novocaine)	☐	☐	☐
Penicillin	☐	☐	☐
Other Antibiotics	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Sedatives	☐	☐	☐
Latex	☐	☐	☐
Metals	☐	☐	☐
Other _____	☐	☐	☐

8. Women Only:

	YES	NO	Not Sure
a) Are you pregnant or think you may be pregnant	☐	☐	☐
b) Are you nursing	☐	☐	☐
c) Are you taking birth control pills	☐	☐	☐

9. Do you have any of the following?

	YES	NO	Not Sure
Aids or HIV infection	☐	☐	☐
Angina	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Cardiac pacemaker	☐	☐	☐
Chest pains	☐	☐	☐
Diabetes	☐	☐	☐
Emphysema	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐
Fainting/Seizures	☐	☐	☐
Hay fever/Allergies	☐	☐	☐
Heart attack	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Murmur	☐	☐	☐
Hepatitis/Jaundice	☐	☐	☐
High blood pressure	☐	☐	☐
Joint replacement	☐	☐	☐
Kidney Disease	☐	☐	☐
Leukemia	☐	☐	☐
Liver disease	☐	☐	☐
Other _____			
Low blood pressure	☐	☐	☐
Pre-Medication	☐	☐	☐
Radiation therapy	☐	☐	☐
Respiratory problems	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Stomach problems	☐	☐	☐
Stroke	☐	☐	☐
Thyroid problems	☐	☐	☐
Tuberculosis	☐	☐	☐

Patient Dental History

	YES	NO	Not Sure
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 in 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 experienced any of the following problems:	YES	NO	Not Sure
a) Clicking Jaw?	☐	☐	☐
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. Have you had orthodontic (braces) work?	☐	☐	☐
11. Have you had prolonged bleeding following extractions?	☐	☐	☐

Signature _____ Date _____

Name of Previous Dentist and Location _____

Date of last exam _____

There is a simple way to whiten teeth, would you be interested? ( ) Yes ( ) No

What did you like least about your last dentist or dental office? _____

_____