

Patient Information

Date _____

Full Name _____ Birth Date _____ Marital Status _____
 Home Address _____ Zip _____ Home Phone _____
 E-Mail _____ Cell Phone _____
 Occupation _____ Employer _____ Social Security No. _____
 Business Address _____ Zip _____ Work Phone _____
 Name of Spouse _____ Occupation _____ Employer _____
 Dental Insurance Company _____ Policy No. _____
 Referred By _____ Previous Dentist _____
 Name of Physician _____ Phone No. _____
 In Case of Emergency Contact _____ Phone No. _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

		Yes	No
1. Have you ever been hospitalized, major operations or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, what? _____			
2. Are you under any medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had any allergic reactions to any drugs including penicillin, codeine, novocaine, aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has there been a change in your health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had kidney dialysis treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had abnormal bleeding problems after a cut or tooth extraction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you now taking drugs or medications?			
If so, what? _____			
10. Has a physician ever informed you that you had:			
Heart Ailment	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	
Angina	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis or Yellow Jaundice			<input type="checkbox"/>
Liver Disease			<input type="checkbox"/>
Venereal Disease			<input type="checkbox"/>
AIDS			<input type="checkbox"/>
Stomach or Intestinal Disease			<input type="checkbox"/>
Kidney Disease			<input type="checkbox"/>
Tumors or Growths			<input type="checkbox"/>
Diabetes			<input type="checkbox"/>
Tuberculosis			<input type="checkbox"/>
Respiratory Disease			<input type="checkbox"/>
Epilepsy			<input type="checkbox"/>
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Women: A. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
B. Estimated Date of Delivery _____			

Signature _____ Date _____

Updating _____

Medical History Summary

Blood Pressure: _____

Dental History

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Please state briefly the reason for your visit. _____ | | |
| 2. Do you have discomfort in your mouth now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. How long since your last dental visit? _____ | | |
| 4. Were X-rays taken of all teeth at that time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do your gums bleed, feel tender or irritated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are your teeth sensitive to hot/cold/sweets? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does food wedge between certain teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are any teeth loose? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you grind, clench or grit your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your jaw ever click or cause pain opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have your front teeth separated creating spaces in them recently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth extracted? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, have they been replaced to prevent shifting and tipping of remaining teeth and bite collapse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Did you ever wear braces? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever worn any dental appliances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever had a root canal? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had gum treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you wear dentures or plates? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are you satisfied with your present dentures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you experienced any growths or sore spots in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have an unpleasant taste in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you floss your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Type of tooth brush _____ hard or soft (circle one) | | |

Updating _____

Dental History Summary
