Patient Medical History

Patient Name_____Address_____Phone #_____
Medical Physician_____Office Phone #_____Date of Last Exam_____
Previous Dentist_____Office Phone #_____Date of Last Exam_____

-Are you allergic to or have you had any reactions to the following? *PLEASE CIRCLE*

Local Anesthetics (eg. Novocaine)
Penicillin or other Antibiotics
Sulfa Drugs
Barbituates
Sedatives
Iodine
Aspirin
Codeine
Other_____

-Are you under medical treatment now:_____
-Have you ever been hospitalized for any surgical operation or serious illness?_____
-Are you taking any medication(s) including non-prescription medicine?
Please list.

Check yes if you have any of the following:
YES

[ ] Do you use tobacco?
[ ] Do you use alcohol, cocaine or other drugs?
[ ] Any reaction to any dental anesthesia?
[ ] Are you having pain or discomfort now?
[ ] Do your gums bleed while brushing or flossing?
[ ] Are your teeth sensitive to hot or cold liquid/foods?
[ ] Are your teeth sensitive to sweet or sour liquid/foods?
[ ] Have you had or been treated for gum disease?
[ ] Do you have any sores or lumps in or near your mouth?
[ ] Have you had any teeth, jaw or neck injuries?
[ ] Do your joints pop, click, catch or hurt?
[ ] Do you have frequent headaches?
[ ] Do you clench or grind your teeth?
[ ] Have you ever had any prolonged bleeding following extractions?
[ ] Have you ever had instructions on the correct method of brushing your teeth?
[ ] Have you ever had instructions on the care of your gums?
[ ] Do you have bad breath?
[ ] Are you happy with the appearance of your teeth?
If not, what would you like changed?

Women Only

[ ] Are you pregnant or think you might be pregnant?
[ ] Are you nursing?
[ ] Are you taking birth control pills?

Do you have or have you had any of the following
PLEASE CIRCLE

- High Blood Pressure
- Low Blood Pressure
- Heart Disease
- Heart Murmur
- Heart attack
- Chest Pains
- Cardiac Pacemaker
- Angina
- Stroke
- Easily Winded
- Frequently Tired
- Fainting/Seizures
- Epilepsy/Convulsions
- Rheumatic Fever
- Tuberculosis
- Anemia
- Glaucoma
- Cancer
- Leukemia
- Liver Disease
- Joint Replacement or Implant
- Kidney Diseases
- Respiratory Problems
- Stomach Trouble/Ulcers
- Swollen Ankles
- Hay Fever/Allergies
- Asthma
- Emphysema
- Radiation Therapy
- Recent Weight Loss
- Arthritis
- Diabetes
- Thyroid Problem
- Hepatitis/Jaundice
- Sexually Transmitted Disease
- AIDS or HIV Infection
- Psychiatric Treatment/ Emotional Problems
- Other_____