Name:______________________________________

Medical History
CONFIDENTIAL

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

	Yes	No
1. Are you in good health?	❒	❒
2. Have there been any changes in your general health within the past year?	❒	❒
3. Date of your last physical exam:__________		
4. Physician's name: __________ Address: __________ Phone no: __________		
5. Are you now under the care of a Physician?	❒	❒
6. Have you ever been hospitalized for any surgical operations or serious illness? If yes, please explain:__________	❒	❒
7. Are you taking any medicine(s) including non-prescription medicine? If yes, list medication: __________	❒	❒
8. Have you had any abnormal bleeding?	❒	❒
9. Do you bruise easily?	❒	❒
10. Have you ever required a blood transfusion?	❒	❒
11. Have you had a recent weight loss?	❒	❒
12. Do you use tobacco?	❒	❒
13. Do you use alcohol or illicit drugs?	❒	❒
14. Are you wearing contact lenses?	❒	❒
15. Do you have any conditions not listed above you think I should be aware of? If yes, please explain:__________	❒	❒

Are you allergic to or have had any reaction to:

	Yes	No
1. Local anesthetic like Novocaine?	❒	❒
2. Penicillin or other antibiotic?	❒	❒
3. Sulfa drugs?	❒	❒
4. Barbiturates, sedatives, or sleeping pills?	❒	❒
5. Aspirin?	❒	❒
6. Iodine?	❒	❒
7. Others? please list:__________	❒	❒

Do you have or have had the following?

	Yes	No
1. Rheumatic heart disease or rheumatic fever?	❒	❒
2. Scarlet fever?	❒	❒
3. Heart defect or heart murmur?	❒	❒
4. Heart trouble, heart attack, or angina?	❒	❒
a. Pain in your chest upon exertion?	❒	❒
b. Shortness or breath after exercise?	❒	❒
c. Do your ankles swell?	❒	❒
d. Shortness of breath when you lie down?	❒	❒
e. Do you require extra pillows when you sleep?	❒	❒
5. Pacemaker?	❒	❒
6. Heart surgery?	❒	❒
7. High or low blood pressure?	❒	❒
8. Hepatitis, jaundice, or liver disease?	❒	❒
9. Stroke?	❒	❒
10. Sinus Trouble?	❒	❒
11. Lung or breathing problems?	❒	❒
12. Asthma or Hay fever?	❒	❒
13. Hives or skin rash?	❒	❒
14. Fainting spells or seizures	❒	❒
15. Diabetes?	❒	❒
16. Aids or HIV infection?	❒	❒
17. Thyroid problems?	❒	❒
18. Arthritis or rheumatism?	❒	❒
19. Allergies? __________	❒	❒
20. Joint replacement or implants?	❒	❒
21. Stomach Ulcer?	❒	❒
22. Kidney trouble?	❒	❒
23. Tuberculosis?	❒	❒
24. Persistent cough?	❒	❒
25. Cough blood?	❒	❒
26. Cancer?	❒	❒
27. Sexually Transmitted Disease (STD)?	❒	❒
28. Epilepsy?	❒	❒
29. Anemia?	❒	❒
30. Leukemia?	❒	❒
31. Glaucoma?	❒	❒
32. Others?	❒	❒

Women ONLY:

	Yes	No
1. Are you pregnant or think you may be?	❒	❒
2. Are you nursing?	❒	❒
3. Are you taking birth control pills?	❒	❒

OVER PLEASE

Dental History

	Yes	No
1. Do your gums bleed while brushing?	❒	❒
2. Do your gums bleed while flossing?	❒	❒
3. Do you feel any pain to any teeth when brushing or flossing them?	❒	❒
4. Are your teeth sensitive to hot, cold, sweet, or sour foods/liquids?	❒	❒
5. Have you noticed any loosening of your teeth?	❒	❒
6. Does food tend to become caught between your teeth?	❒	❒
7. Do you have any sores or lumps in or near your mouth?	❒	❒
8. Have you experienced any of the following problems in your jaw:		
a. Clicking?	❒	❒
b. Pain (joint, ear, side of face)?	❒	❒
c. Difficulty in opening or closing?	❒	❒
d. Difficulty chewing?	❒	❒
9. Have you had any head, neck, or jaw injuries?	❒	❒
10. Do you clench or grind your teeth?	❒	❒
11. Do you bite your lip or cheek frequently?	❒	❒
12. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plate or other appliance?	❒	❒
13. Are you satisfied with the appearance of your teeth?	❒	❒
14. Have you ever had an upsetting experience in the dental office? If yes, please explain below.	❒	❒
15. Is there anything about your dental treatment that bother you? If yes, please explain below.	❒	❒

NOTES:

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X______________________________ ______________________________

Signature of patient or parent if minor Date

Updates:

______ ______ ______ ______

______ ______ ______ ______

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