PATIENT MEDICAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH_____

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 INTER-RELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANWERING THE FOLLOWING QUESTIONS.

		Circle one	
1.	Are you in good health……..……....	Y	N
2.	Have there been any changes in your general health within the past year……..……..	Y	N
3.	Date of your last physical exam_____		
4.	Physician's Name_____		
	Address_____		
	Phone No. _____		
5.	Are you now under the care of a physician..….	Y	N
6.	Have you ever been hospitalized for any surgical operation or serious illness…….…….	Y	N
	Please explain: _____		
	_____		
7.	Are you taking any medicine(s) ……	Y	N
	Including non-prescription medicine……..….	Y	N
	If yes, what medicine(s) are you taking_____		
	_____		
8.	Have you had any abnormal bleeding…….…...	Y	N
9.	Do you bruise easily…….……..	Y	N

		Circle one	
10.	Have you ever received radiation treatment to your head or neck……...	Y	N
11.	Have you ever taken Boniva, Bisphosphenates, or any other osteoporosis medication……..….	Y	N
12.	Have you ever required a blood transfusion……..	Y	N
13.	Have you had a recent weight loss……..….	Y	N
14.	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ……...……	Y	N
15.	Do you have any disease, condition or problem not listed above that you think I should know about……..…...	Y	N

WOMEN ONLY

Are you pregnant or think you may be pregnant.	Y	N
Are you nursing…….	Y	N
Are you taking birth control pills……..	Y	N

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

LOCAL ANESTHETICS LIKE NOVOCAINE …..…	Y	N
PENICILLIN OR OTHER ANTIBIOTICS …….....	Y	N
SULFA DRUGS ……..	Y	N
BARBITURATES, SEDATIVES OR SLEEPING PILLS	Y	N
ASPIRIN ……...	Y	N
IODINE ……..	Y	N
ANY METALS (E.G. NICEL, MERCURY, ETC)…..	Y	N
LATEX / RUBBER ……..	Y	N
OTHER (PLEASE LIST) _____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	Y	N
SCARLET FEVER…….	Y	N
HEART DEFECT OR HEART MURMUR……	Y	N
HEART TROUBLE, HEART ATTACK, OR ANGINA.	Y	N
CHEST PAIN……..	Y	N
SHORTNESS OF BREATH ……..	Y	N
PACEMAKER ……	Y	N
HEART SURGERY……..	Y	N
HIGH/LOW BLOOD PRESSURE ……..	Y	N
CONGENITAL HEART PROBLEM ……	Y	N
SWELLING OF FEET, ANKLES, HANDS ……..	Y	N
HEPATITIS, JAUNDICE OR LIVER DISEASE…….	Y	N
STROKE …….	Y	N
HYPOGLYCEMIA ……	Y	N
SINUS TROUBLE……..	Y	N
LUNG OR BREATHING PROBLEMS …….	Y	N
ASTHMA OR HAY FEVER ……..	Y	N
OSTEOPOROSIS……	Y	N
HIVES OR SKIN RASH ……..	Y	N
FAINTING OR DIZZY SPELLS……..	Y	N
DIABETES…….	Y	N
AIDS OR HIV INFECTION …….	Y	N
THYROID PROBLEMS ……...	Y	N
ARTHRITIS OR RHEUMATISM ……..	Y	N
JOINT REPLACEMENT OR IMPLANT ……..	Y	N
STOMACH ULCER ……..	Y	N
KIDNEY TROUBLE ……..	Y	N
TUBERCULOSIS……	Y	N
PERSISTANT COUGH……	Y	N
COUGH THAT PRODUCES BLOOD ……..……..	Y	N
CHEMOTHERAPY ……	Y	N
SEXUALLY TRANSMITTED DISEASE ……..	Y	N
EPILEPSY OR SEIZURES ……	Y	N
ANEMIA ……..	Y	N
GLAUCOMA ……	Y	N
TONSILLITIS …….	Y	N
TUMORS ……..	Y	N
MENTAL HEALTH CARE ……..	Y	N
BACK PROBLEMS ……	Y	N
CHEMICAL DEPENDENCY ……..	Y	N
MITRAL VALVE PROLAPSE……..….	Y	N
COLD SORES / FEVER BLISTERS ……..	Y	N
EATING DISORDERS……..…	Y	N

PATIENT DENTAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH_____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN / WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____HOW OFTEN DO YOU FLOSS YOUR TEETH _____

	Circle one			Circle one	
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING ….	Y	N	DO YOU HAVE FREQUENT HEADACHES……	Y	N
ARE YOUR TEETH SENSITIVE TO HOT OR COLD			DO YOU CLENCH OR GRIND YOUR TEETH …….	Y	N
LIQUIDS / FOODS ……......	Y	N	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY…..	Y	N
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR			HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH ..	Y	N
LIQUIDS / FOODS ……......	Y	N	DOES FFOD TEND TO BECOM CAUGHT BETWEEN		
DO YOU FEEL PAIN ON ANY OF YOUR TEETH ……...	Y	N	YOUR TEETH…...……	Y	N
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR			HAVE YOU EVER HAD PERIODONTAL		
YOUR MOUTH ……......	Y	N	TREATMENT (GUMS) …….....	Y	N
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES ……..	Y	N	EVER WORN A BITE PLATE OR OTHER APPLIANCE……	Y	N
HAVE YOU EVER EXPERIENCED ANY OF THE			DO YOU WEAR DENTURES OR PARTIALS ……...	Y	N
FOLLOWING PROBLEMS IN YOUR JAW?			IF YES, DATE OF PLACEMENT _____		
CLICKING……......	Y	N			
PAIN (JOINT, EAR, SIDE OF FACE) …….	Y	N	HAVE YOU EVER RECEIVED ORAL HYGIENE		
DIFFICULTY IN OPENING OR CLOSING …….....	Y	N	INSTRUCTIONS REGARDING THE CARE OF YOUR		
DIFFICULTY IN CHEWING ……...	Y	N	TEETH AND GUMS ……	Y	N

IF YOU COULD CHANGE <u>ANYTHING</u> ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

_____

_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE I NFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDER-STAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEATLH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN OF MINOR

DOCTOR'S COMMENTS _____

_____

_____SIGNATURE_____ DATE_____

HEALTH HISTORY

Patient Number_____