

PATIENT MEDICAL HISTORY



PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

Answer yes or no.

Are you under medical treatment now?

Are you allergic to or have you had any reactions to the following?

Have you ever been hospitalized for any surgical Operation or serious illness?

Local anesthetics (i.e. Novacaine)

Barbiturates

Are you taking any medication(s) including Non-prescription medicine?

Aspirin

Sedatives

If yes, what medication(s) are you taking?

Penicillin or other antibiotics

Sulfa drugs

Iodine

Other _____

Do you use tobacco?

Do you use alcohol, cocaine, or other drugs?

Do you have or have you had any of the following? (Circle all that apply)

High Blood Pressure

Heart Disease

Heart Attack

Chest Pains

Easily Winded

Stroke

Hay Fever / Allergies

Tuberculosis

Radiation Therapy

Glaucoma

Recent Weight Loss

Liver Disease

Heart Trouble

Respiratory Problems

Cardiac Pacemaker

Rheumatic Fever

Heart Murmur

Swollen Ankles

Angina

Fainting / Seizures

Fraternity Tired

Asthma

Anemia

Low Blood Pressure

Emphysema

Epilepsy / Conclusions'

Cancer

Leukemia

Arthritis

Diabetes

Joint Replacement or Implant

Kidney Diseases

Hepatitis / Jaundice

AIDS or HIV Infection

Sexually Transmitted Diseases

Thyroid Problem

Stomach Troubles / Ulcers

Other _____

PATIENT DENTAL HISTORY

Answer yes or no to the following.

Do your gums bleed while brushing or flossing?

Are your teeth sensitive to hot or cold liquids / foods?

Are your teeth sensitive to sweet or" sour liquids / foods?

Do you feel pain to any of your teeth?

Do you have any sores or lumps in or near your mouth?

Have you had any head, neck or jaw injuries

Do you have frequent headaches?

Do you clench or grind your teeth?

Do you bite your lips or cheeks frequently?

Have you ever had any difficult extractions in the past?

Have you had any orthodontic work?

Have you ever had prolonged bleeding following extractions?

Have you ever had instruction on the correct method of brushing

Have you ever had instructions on the care of your gums?

Your teeth? -

Have you ever experienced any of the following Problems in your jaw?

Clicking?

Pain (joint, ear, side of face)?

Difficulty in opening or closing?

Difficulty in chewing?

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing Incorrect information can be dangerous to my health.

Signature X _____ Date: _____