PATIENT HEALTH HISTORY

How would you describe your health? _____ Date of Last

Name of Physician _____ Medical Exam: _____

	Yes	No
1. Are you now or have you been under the care of a physician within the past five years? If so, why? _____	☐	☐
2. Have you ever had any major surgery or hospitalization? _____ Date: _____	☐	☐
3. Are you now or have you recently been taking any medication? If so, for what? _____	☐	☐
4. Are you taking any bisphosphonates for cancer treatment or osteoporosis? _____	☐	☐
5. Have you taken Phen-fen before? When? _____ Have you seen your physician after that? _____	☐	☐

6. Are you allergic or have any reactions to the following: (*Mark each applicable box*)

Yes	No		Yes	No		Yes	No	
☐	☐	Local anesthetics (e.g. Novocaine, Epinephrine)	☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Penicillin or other antibiotics _____	☐	☐	Codeine	☐	☐	Any metals (e.g. nickel, mercury)
		_____	☐	☐	Barbiturates	☐	☐	Latex rubber
☐	☐	Sulfa Drugs	☐	☐	Sedatives			

Other allergies: _____

7. **WOMEN ONLY**

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. **DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:** (*Mark each applicable box*)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Angina Pectoris	☐	☐	Arthritis	☐	☐	Blood Transfusion	☐	☐	Bad Breath
☐	☐	Artificial Heart Valve	☐	☐	Asthma	☐	☐	Cortisone Medicine	☐	☐	Bleeding Gums
☐	☐	Congenital Heart Defect	☐	☐	Cancer	☐	☐	Epilepsy or Seizures	☐	☐	Cold Sores
☐	☐	Mitral Valve Prolapse	☐	☐	Chemotherapy	☐	☐	Genital Herpes	☐	☐	Chronic Headaches
☐	☐	Heart Attack	☐	☐	Radiation Therapy	☐	☐	Glaucoma	☐	☐	Chronic Neck Aches
☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐	Gonorrhea	☐	☐	Cosmetic Surgery
☐	☐	Heart Failure	☐	☐	Emphysema	☐	☐	Hemophilia	☐	☐	Drug Addiction
☐	☐	Heart Surgery	☐	☐	Hay Fever / Allergies	☐	☐	Hepatitis A (Infectious)	☐	☐	Fainting / Dizzy Spells
☐	☐	Heart Murmur	☐	☐	Joint Replacement / Implant	☐	☐	Hepatitis B (Serum)	☐	☐	Nervousness
☐	☐	High Blood Pressure	☐	☐	Kidney Trouble	☐	☐	HIV Infection or AIDS	☐	☐	Pain in Jaw Joints
☐	☐	Pacemaker	☐	☐	Sinus Trouble	☐	☐	Leukemia	☐	☐	Psychiatric Treatment
☐	☐	Rheumatic Fever	☐	☐	Thyroid Disease	☐	☐	Liver Disease	☐	☐	Sickle Cell Disease
☐	☐	Scarlet Fever	☐	☐	Tuberculosis	☐	☐	Syphilis	☐	☐	Tooth Pain
☐	☐	Stroke	☐	☐	Ulcers	☐	☐	Yellow Jaundice			

Others not listed: _____

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location: _____ Date of Last Exam: _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids / foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids / foods?	☐	☐
4. Do you feel any pain on any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you ever had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face).	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Has bleeding ever prolonged following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, Date of Placement: _____		
15. Have you ever received oral hygiene instructions	☐	☐
regarding the care of your teeth and your gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such dental care to third party payors and /or health practitioners.

Signature of Patient / Parent or Guardian: _____ Date: _____

Doctor's Comments: _____

_____

_____

Doctor's Signature: _____ Date: _____