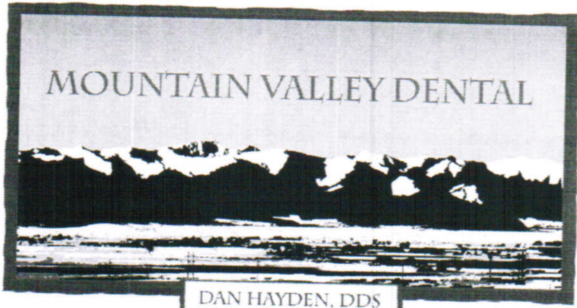


## PATIENT MEDICAL HISTORY

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? If yes, please explain: ______ | ☐ | ☐ |
| 2. Have you been hospitalized for any surgical operation or serious illness within the last year? If yes, please explain: ______ | ☐ | ☐ |
| 3. Are you allergic to or have you had any reactions to the following medications? | | |
| *Local Anesthetics (e.g. Novocain)* | ☐ | ☐ |
| *Penicillin* | ☐ | ☐ |
| *Codeine* | ☐ | ☐ |
| *Clindamycin* | ☐ | ☐ |
| *Anti-inflammatories* | ☐ | ☐ |
| *Acetaminophen (Tylenol)* | ☐ | ☐ |
| *Sulfa Drugs* | ☐ | ☐ |
| *Latex* | ☐ | ☐ |
| *Other (please list)* ______ | | |
| 4. Women Only: | | |
| a) Are you pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |
| 5. Are you taking any medication(s) or drugs? If yes, list medication, condition it treats, and how often it is taken: | ☐ | ☐ |

| *Medication* | *Condition/How Often* | |
|---|---|---|
| ______ | ______ | ______ |
| ______ | ______ | ______ |
| ______ | ______ | ______ |

| | Yes | No |
|---|---|---|
| 6. Do you use tobacco? | ☐ | ☐ |
| If yes, type of tobacco user: | | |
| Cigarette | ☐ | ☐ |
| Cigar/Pipe | ☐ | ☐ |
| Smokeless tobacco | ☐ | ☐ |
| How frequently: Less than a pack/day | ☐ | ☐ |
| Pack a day | ☐ | ☐ |
| More than a pack/day | ☐ | ☐ |

For office use only (question 6): Dr. Initial: ______

| | | |
|---|---|---|
| a) Patient advised to quit? | ☐ | ☐ |
| b) Patient is interesting in quitting? | ☐ | ☐ |
| c) Discussed quit materials/quit-line? | ☐ | ☐ |

Reviewed by: ______ Update: ______ Update: ______

Update: ______ Update: ______ Update: ______ Update: ______

7. Please complete the following:

| | Yes | No |
|---|---|---|
| *Heart Attack* ... *Date* ______ | ☐ | ☐ |
| *Heart Disease* | ☐ | ☐ |
| *Heart Murmur* | ☐ | ☐ |
| *Rheumatic Fever* | ☐ | ☐ |
| *Joint Replacement or Implant..Type* ______ *Date* ______ | ☐ | ☐ |
| *Artificial Heart Valve* ... *Date* ______ | ☐ | ☐ |
| *Stroke* ... *Date* ______ | ☐ | ☐ |
| *High Blood Pressure* | ☐ | ☐ |
| *Cardiac Pacemaker* | ☐ | ☐ |
| *Diabetes* | ☐ | ☐ |
| *Angina* | ☐ | ☐ |
| *Fainting/Seizures* | ☐ | ☐ |
| *Epilepsy/Convulsions* | ☐ | ☐ |
| *Anemia* | ☐ | ☐ |
| *Emphysema* | ☐ | ☐ |
| *Cancer* ... *Type* ______ ... *Date* ______ | ☐ | ☐ |
| *Arthritis* | ☐ | ☐ |
| *Leukemia* | ☐ | ☐ |
| *Asthma* | ☐ | ☐ |
| *Tuberculosis* | ☐ | ☐ |
| *Liver Disease* | ☐ | ☐ |
| *Hepatitis – please circle: A B C* | ☐ | ☐ |
| *Ulcers* | ☐ | ☐ |
| *Kidney Disease* | ☐ | ☐ |
| *AIDS or HIV infection* | ☐ | ☐ |
| *Thyroid Problem* | ☐ | ☐ |
| *Psychiatric Condition* | ☐ | ☐ |
| *Hemophilia/Bleeding Disorders* | ☐ | ☐ |
| *Have you treated for osteoporosis(Bisphosphonates)* | ☐ | ☐ |
| *Other* ______ | | |

## PATIENT DENTAL HISTORY

- Please list reason for visit today: ______
- State long term dental goals: ______
- Name of previous Dentist and Location: ______

| | Yes | No |
|---|---|---|
| • Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| • Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| • Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| • Do you clinch or grind your teeth? | ☐ | ☐ |
| • Have you had any orthodontic treatment? | ☐ | ☐ |
| • If yes, date of placement: ______ | | |
| • Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| • Are you interested in improving your smile (whiter teeth)? | ☐ | ☐ |

## AUTHORIZATION AND RELEASE

*I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and results of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance 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.*

______ Date: ______
Signature of Patient (or Parent if Minor):

PHYSICIAN: ______

BLOOD PRESSURE: ______ ______ ______