Patient Name _____ Todays Date _____

Home Address _____ Date of Birth _____

_____ Home Phone _____

E-Mail _____ Cell Phone _____

Employer _____ Business Phone _____

Insurance CO _____ SS# _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last exam _____

Are you under medical treatment now? Yes No _____

Have you ever been hospitalized for any surgical operation or serious illness? Yes No

Are you taking any medication(s) Including non-prescription Medicine? Yes No

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

Do you use tobacco? Yes No

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

Local anesthetics	Yes No	**Sulfa Drugs**	Yes No	**Women Only:**
Penicillin	Yes No	**Latex**	Yes No	Are you pregnant? Yes No
Other antibiotics	Yes No			Are you nursing? Yes No
				Taking birth control? Yes No

Do you have or have you had any of the following?

High Blood Pressure	Yes No	Heart Attack	Yes No	Rheumatic Fever	Yes No
Fainting/Seizures	Yes No	Asthma	Yes No	Low Blood Pressure	Yes No
Epilepsy/Convulsions	Yes No	Leukemia	Yes No	Diabetes	Yes No
Kidney Diseases	Yes No	AIDS or HIV	Yes No	Thyroid Problem	Yes No
Heart Disease	Yes No	Pacemaker	Yes No	Heart Murmur	Yes No
Angina	Yes No	Emphysema	Yes No	Bisphosphonate Use	Yes No
Arthritis	Yes No	Chest Pains	Yes No	Joint Replacement	Yes No
Hepatitis/Jaundice	Yes No	Stroke	Yes No	Stomach Troubles	Yes No
Hay Fever/Allergies	Yes No	Tuberculosis	Yes No	Radiation Therapy	Yes No
Respiratory Problems	Yes No	Liver Disease	Yes No	Recent Weight Loss	Yes No
Mitral Valve Prolapse	Yes No	Cancer	Yes No	Other _____	

PATIENT DENTAL HISTORY

Do your gums bleed while brushing or flossing?	Yes No	Dou you have frequent headaches?	Yes No
Are your teeth sensitive to hot/cold?	Yes No	Do you clench or grind your teeth?	Yes No
Are your teeth sensitive to sweets/sour?	Yes No	Do you bite your lips or cheeks	Yes No
Have you ever had any difficult extractions?	Yes No	Do you feel pain to any of your teeth	Yes No
Do you have any sores or lumps in mouth area?	Yes No	Have you had orthodontic treatment	Yes No
Have you had any head, neck or jaw injuries?	Yes No	Have you ever had prolonged bleeding	Yes No
Have you ever experienced any of the following Problems in your jaw?		Have you ever had instructions on the correct method of brushing your teeth?	Yes No
• Clicking?	Yes No	Have you ever had instructions on the	
• Pain (joint, ear, side of face)?	Yes No	care of your gums?	Yes No
• Difficulty in opening or closing?	Yes No		
• Difficulty in chewing?	Yes No		

Signature X _____ Date _____