WELCOME!

Patient Medical History

Name of current physician_____ Office No.:_____ Date of last exam._____

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? I yes, please, explain _____ ☐ Yes ☐ No

_____

3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? ☐ Yes ☐ No

_____

4. Have you ever taken Fosamax, Boniva, Actomel or any cancer medications containing bisphosphonates? ☐ Yes ☐ No
5. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ☐ Yes ☐ No
6. Do you use tobacco? ☐ Yes ☐ No
7. Do you use controlled substances? ☐ Yes ☐ No
8. Do you have or have you had any of the following? ☐ Yes ☐ No

High blood pressure	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Cardiac Pacemaker	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Angina (cardiac)	☐ Yes	☐ No
Fainting/Seizures	☐ Yes	☐ No	Frequently tired	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Joint Replacement or Implant	☐ Yes	☐ No
Kidney Diseases	☐ Yes	☐ No	Hepatitis/Jaundice	☐ Yes	☐ No
AIDS or HIV Infection	☐ Yes	☐ No	Sexually transmitted disease	☐ Yes	☐ No

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Thyroid Problem	☐ Yes ☐ No	Stomach Troubles/Ulcers	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Hay Fever/Allergies	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Liver diseases	☐ Yes ☐ No	Heart Trouble	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No		☐ Yes ☐ No

OTHER

10. Are you wearing contact lenses?	☐ Yes ☐ No
11. Are you allergic to or have you had any reactions to the following?	☐ Yes ☐ No
Local Anesthetics (e.g.: Lidocaine)	☐ Yes ☐ No
Penicillin or any other Antibiotics	☐ Yes ☐ No
Sulfa drugs	☐ Yes ☐ No
Barbiturates	☐ Yes ☐ No
Sedatives	☐ Yes ☐ No
Iodine	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No
Any metals (e.g.: nickel, mercury etc.)	☐ Yes ☐ No
Latex Rubber	☐ Yes ☐ No
Other	☐ Yes ☐ No
12.Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐ Yes ☐ No
13. Women only:	☐ Yes ☐ No
a) are you pregnant or think you may be pregnant?	☐ Yes ☐ No
b) Are you nursing?	☐ Yes ☐ No
c) Are you taking oral contraceptives?	☐ Yes ☐ No

Patient Dental History

1. Do your gums bleed while brushing or flossing?	☐ Yes ☐ No	8. Do you have frequent headaches?	☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods?	☐ Yes ☐ No	9.Do you clench or grind your teeth?	☐ Yes ☐ No

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3. Are your teeth sensitive to sweet or sour liquids/foods?	☐ Yes	☐ No	10. Do you bite your lips or cheeks frequently?	☐ Yes	☐ No
4. Do you feel pain to any of your teeth?	☐ Yes	☐ No	11. Have you ever had any difficult extractions in the past?	☐ Yes	☐ No
5. Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No	12. have you ever had any prolonged bleeding following extractions?	☐ Yes	☐ No
6. Have you had any head, neck or jaw injuries?	☐ Yes	☐ No	13. Have you had any orthodontic treatment?	☐ Yes	☐ No
7. Have you ever experienced any of the following problems in your jaw?	☐ Yes	☐ No	14.Do you wear the dentures or partials? If yes, date of placement_____	☐ Yes	☐ No
Clicking	☐ Yes	☐ No	15. Have you ever received oral hygienic instructions regarding the care of your teeth and gums?	☐ Yes	☐ No
Pain (joint, ear, side of face)	☐ Yes	☐ No	16. Do you like your smile?	☐ Yes	☐ No
Difficulty in opening or closing	☐ Yes	☐ No			
Difficulty in chewing	☐ Yes	☐ No			

Authorization

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts cash and credit card payment. I understand that I am responsible for payment of services rendered that my insurance does not cover. I understand that, I am responsible for all costs of dental treatment.

I understand that, the information that I have given today is correct to the best of my knowledge. I also understand that, this information will be in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to render necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of patient (or parent/guardian if junior) _____

Date _____

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