



Accurate answers will help us provide you the safest treatment experience. All information you provide is confidential.

If you need assistance or have a question, please ask.

Patient's Name \_\_\_\_\_  
Last First Middle Today's Date

## PATIENT MEDICAL HISTORY

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Your PHYSICIAN'S name and phone # \_\_\_\_\_

Yes  No  Have you ever been hospitalized or had surgery?  
If yes, please give year and reasons or types of operations. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.**

### MEDICATIONS

Have you ever taken any of the following:

- Yes  No  cortisone, steroids
- Yes  No  heparin, coumadin, blood thinners, anticoagulants
- Yes  No  antidepressants, sedatives, psychiatric medicine
- Yes  No  heart or blood pressure medications
- Yes  No  nitroglycerin
- Yes  No  Fen-Phen, Pondimin, Redux

Please list all prescription and over-the-counter medications you are currently taking \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Yes  No  Any change in your general health in the last year?
- Yes  No  weight change greater than 10 pounds in the last year
- Yes  No  do you exercise regularly
- Yes  No  heart murmur, rheumatic fever
- Yes  No  mitral valve prolapse
- Yes  No  angina, chest pain
- Yes  No  heart attack, heart disease
- Yes  No  pacemaker, irregular heart beat
- Yes  No  heart surgery
- Yes  No  high blood pressure
- Yes  No  stroke, embolus, thrombosis
- Yes  No  swollen ankles
- Yes  No  difficulty breathing at night
- Yes  No  asthma, hayfever
- Yes  No  tuberculosis, T.B.
- Yes  No  emphysema, pneumonia
- Yes  No  persistent cough, bronchitis
- Yes  No  seizure disorder, epilepsy, convulsion

- Yes  No  severe headaches, migraines
- Yes  No  fainting, dizziness
- Yes  No  eating disorder, anorexia, bulimia
- Yes  No  depression, psychosis, schizophrenia
- Yes  No  psychiatric care, counseling
- Yes  No  neurological or neuromuscular disorder
- Yes  No  ulcer or stomach problem
- Yes  No  chronic diarrhea, intestinal problem
- Yes  No  kidney or bladder problem
- Yes  No  sexually transmitted disease
- Yes  No  hepatitis, cirrhosis, liver disease
- Yes  No  eye problems or disease
- Yes  No  sinus problems or infection
- Yes  No  ear problems or infection
- Yes  No  diabetes or high blood sugar
- Yes  No  swollen glands or lymph nodes
- Yes  No  been tested for HIV
- Yes  No  HIV+, ARC, AIDS
- Yes  No  bleeding problem, hemophilia
- Yes  No  bruise easily, slow healing
- Yes  No  blood disorder, blood transfusion, sickle cell
- Yes  No  artificial joints
- Yes  No  arthritis, joint pain, back problems
- Yes  No  skin problem or disease
- Yes  No  cancer or tumor
- Yes  No  radiation treatment, chemotherapy
- Yes  No  past or present drug use including cocaine, crack, methamphetamine, etc.
- Yes  No  do you smoke? # of packs per day \_\_\_\_\_ for how long? \_\_\_\_\_
- Yes  No  chewing tobacco or snuff
- Yes  No  do you drink alcohol? # of drinks per week \_\_\_\_\_
- Yes  No  do you participate in any sports \_\_\_\_\_

**ALLERGIES**

Do you have any of the following allergies:

- Yes  No  Penicillin, sulfa, any antibiotic
- Yes  No  local anesthetics (novocaine, lidocaine, etc.)
- Yes  No  aspirin, codeine, or other pain medication
- Yes  No  hives, contact dermatitis, latex sensitivity
- Yes  No  allergic to an other medication \_\_\_\_\_

Yes  No  Do you have any disease, condition or problem not listed above? \_\_\_\_\_  
 \_\_\_\_\_

**WOMEN ONLY**

- Yes  No  are you pregnant or possibly pregnant
- Yes  No  are you nursing
- Yes  No  are you taking birth control pills

**DENTAL HISTORY**

- Yes  No  tooth or mouth pain recently
- Yes  No  how nervous does dental treatment make you:  
 \_\_\_\_ not at all \_\_\_\_ slightly  
 \_\_\_\_ moderately \_\_\_\_ extremely
- Yes  No  do you clench or grind your teeth
- Yes  No  jaw clicking, popping, or grinding
- Yes  No  jaw or TMJ pain
- Yes  No  ever worn partials or dentures
- Yes  No  orthodontic treatment / braces
- Yes  No  ulcers / sores in mouth or on lips
- Yes  No  unpleasant taste / bad breath
- Yes  No  swelling, lumps, bumps in mouth
- Yes  No  periodontal / gum surgery or disease
- Yes  No  oral surgery
- Yes  No  any unpleasant experience with dental treatment. If yes, describe \_\_\_\_\_  
 \_\_\_\_\_

Yes  No  any complication with / reaction to past dental treatment

Yes  No  any injury to your teeth, mouth, jaws, or head

Reason for today's visit \_\_\_\_\_  
 \_\_\_\_\_

How do you feel about the appearance of your front teeth  
 \_\_\_\_\_  
 \_\_\_\_\_

Yes  No  do you have any other dental concerns  
 \_\_\_\_\_

Previous dentists name \_\_\_\_\_  
 City \_\_\_\_\_  
 Date of last dental treatment \_\_\_\_\_

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be very dangerous to my health. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest time, and I agree to do so.**

\_\_\_\_\_  
 Signature Date Relationship to patient if other than self

**AUTHORIZATION FOR USE OF IMAGE AND BIOGRAPHICAL INFORMATION**

I am a patient of Dr. \_\_\_\_\_ . I understand that my dentist may take video or still images of the work that he is doing. I consent to my dentist, or a representative of his staff, taking these images. I understand that my dentist may use my images, and biographical information that I provide to my dentist, for purposes of education, publicity, promotion and advertising. I understand that I will receive no remuneration for such use.

\_\_\_\_\_  
 Signature Date