PATIENT MEDICAL HISTORY

Patient's Name:_____ Best Phone:_____ Alternate Phone:_____

Physician's Name: _____ Physician Phone:_____ Birthdate:_____

Preferred Pharmacy: _____ Pharmacy Phone: _____ Age: _____

Please list any Medications you are currently taking: _____
Are you currently undergoing any type of medical treatment? _____
Have you had any major operations? If yes, what kind?_____
Do you smoke or use tobacco? _____ Packs per day? _____ Do you currently take Aspirin on daily basis? _____
If female: Are you taking Birth Control Pills? _____ Are you or could you be pregnant? _____

Y	N	**Conditions**
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Artificial Heart Valve/Stents/Shunts
☐	☐	Arthritis, Osteo/Rheumatoid
☐	☐	Artificial Joints, Implants
☐	☐	Asthma
☐	☐	Cancer - Chemotherapy
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Donor Organs
☐	☐	Drug Abuse
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV + AIDS
☐	☐	Heart Attack
☐	☐	Heart Surgery

Y	N	**Conditions**
☐	☐	Hemophilia
☐	☐	Hepatitis A, B, C
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Nervous Problems or Disorders
☐	☐	Osteoporosis
☐	☐	Pacemaker
☐	☐	Pain In Jaw Joints
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Recreational Drugs
☐	☐	Seizures
☐	☐	Sexually Transmitted Diseases
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Tumors or Growths
☐	☐	Ulcers

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other: _____

_____

_____

Have you ever taken any of the following medications?

Y	N	
☐	☐	Actonel
☐	☐	Aredia
☐	☐	Boniva
☐	☐	Fosamax
☐	☐	Zometa
☐	☐	Other Meds for Bone Density:

Is there any disease, condition or problem that you think the doctor should know about that is not covered above?

_____

Patient Signature _____ Date: _____

If under age 18, Parent or Guardian Signature Required

Office Use Only

Pre-med required YES / NO Date:_____

Date	Doctor's Signature	B/P
		/
		/
		/
		/
		/
		/
		/
		/
		/

PATIENT DENTAL HISTORY

Are you having any dental discomfort at this time? ☐ Yes ☐ No

Please describe: _____

Are your teeth sensitive; ☐ to hot only? ☐ to cold only? ☐ to both hot & cold ☐ when biting & chewing

On a scale of 1-10 please circle the number which best describes your discomfort 10 being the worst:

☺ ☹

1 2 3 4 5 6 7 8 9 10

Please answer YES or NO to the following conditions:

Y/N Conditions:	Y/N Conditions:
☐☐ swelling or lumps in mouth	☐☐ grinding or clenching
☐☐ bleeding gums	☐☐ nasal obstruction
☐☐ bad breath	☐☐ previous orthodontics.
☐☐ bad taste	year braces came off _____
☐☐ previous trauma to head or mouth	☐☐ previous gum surgery. Year _____
☐☐ temple headaches	☐☐ wisdom teeth present
☐☐ popping or clicking in joint	☐☐ wear dentures
☐☐ ear aches	☐☐ chew lip, tongue, fingernails, pencils, pens

How often do you usually visit a dentist? _____

How long has it been since you have seen a dentist? _____ Reason for leaving: _____

Do you have a fear of having dentistry done? ☐ Yes ☐ No. Why? _____

Main reason for today's visit: _____

How do you feel about your teeth? _____

NAME_____ DATE_____