Patient Medical History:

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Email: _____SS #:_____

Birth date: _____ Age: _____ Sex: ☐ Male ☐ Female

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered ☐ Minor

Occupation: _____ Employer/School: _____

Spouse's Name:_____ Birth date: _____

In Case of Emergency, Contact: Name: _____

Relationship: _____Phone # _____

Whom may we thank for referring you? _____

Dental History:

Former Dentist: _____ Address: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

How often do you brush? _____How often do you floss? _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Gums swollen or tender	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Sensitivity	☐ Yes ☐ No
Sores on lips or mouth	☐ Yes ☐ No	Broken Fillings	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No	Mouth Breathing	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Jaw Pain	☐ Yes ☐ No	Periodontal Treatment	☐ Yes ☐ No
Lip or cheek biting	☐ Yes ☐ No	Endodontic treatment	☐ Yes ☐ No
Loose teeth	☐ Yes ☐ No	Food collection between teeth	☐ Yes ☐ No
Burning sensation	☐ Yes ☐ No		

Medical History:

Physician name: _____ Physician Phone: (_____) _____

Pharmacy: _____ Pharmacy Phone: (_____) _____

Over Please

Please mark “Yes” or “No” to indicate if you have had any of the following conditions or allergies:

Conditions:

AIDS/HIV	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No
Artificial Bones/Joints	☐ Yes ☐ No
Aspirin Regimen	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No
Bleeding Problems	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No
Cough - Persistent	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No
Fainting Spells	☐ Yes ☐ No
Headaches	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No
Hepatitis: A or B or C	☐ Yes ☐ No
Herpes	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Jaw Pain	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Nervous Problems	☐ Yes ☐ No
Pace Maker	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No
Radiation Therapy	☐ Yes ☐ No
Respiratory Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Sinus Problems	☐ Yes ☐ No
Skin Rash	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Swollen Feet or Ankles	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No
Do you smoke or use tobacco?	☐ Yes ☐ No

Allergies:

Amoxicillin	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No
Dental Anesthetics	☐ Yes ☐ No
Erythromycin	☐ Yes ☐ No
Sulfur	☐ Yes ☐ No
Latex	☐ Yes ☐ No
Metals	☐ Yes ☐ No
Milk	☐ Yes ☐ No
Motrin	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No
Tetracycline	☐ Yes ☐ No

Other: _____

Medications:

Please list any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

_____

_____

_____

Women:

Are you taking Birth Control Pills?	☐ Yes ☐ No
Are you Pregnant?	☐ Yes ☐ No
If yes, # of weeks _____	
Are you nursing?	☐ Yes ☐ No