PATIENT HISTORY.

PATIENT NAME: ______ AGE: ______ DATE: ______

MEDICAL HISTORY

- ◯ Yes ◯ No Are you in good health at the present time?
- ◯ Yes ◯ No Are you presently under the care of a physician for some illness or disease?
- ◯ Yes ◯ No Have you been hospitalized or had a serious illness in the last 3 years? If yes, when? ______
- ◯ Yes ◯ No Do you have a bleeding tendency or slow healing of wounds?
- ◯ Yes ◯ No Are you allergic to or had a reaction to any drugs or medications? Name the drugs: ______
- ◯ Yes ◯ No Have you ever had a reaction to a dental injection or anesthetic?
- ◯ Yes ◯ No Are there any other medical or dental problems we should know about?
- ◯ Yes ◯ No Do you smoke or us tobacco products? If yes, for how long? ______
- ◯ Yes ◯ No WOMEN ONLY Are you pregnant? If yes, How many months: ______ Due Date: ______

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

◯ Rheumatic Fever	◯ Epilepsy	◯ Liver Disease	◯ High/Low Blood Pressure		◯ Diabetes
◯ Asthma/Hay Fever	◯ Stomach Ulcers	◯ Nervous Condition	◯ Fainting Spells/Seizures	◯ Radiation Therapy	◯ Anemia
◯ Hepatitis/Jaundice	◯ Heart Trouble	◯ Arthritis	◯ Veneral Disease/ HIV/ AIDS	◯ Latex allergy	

DENTAL HISTORY

- ◯ Yes ◯ No Have you ever had a bad dental experience or are you nervous when visiting the dentists?
- ◯ Yes ◯ No Do your gums ever bleed or feel sore? ◯ Yes ◯ No Do any of your teeth feel loose?
- ◯ Yes ◯ No Have you ever noticed your teeth shifting or have you noticed a change in your bite?
- ◯ Yes ◯ No Have you ever had periodontal treatments and/or surgery related to your gums?
- ◯ Yes ◯ No Do you have frequent or chronic headaches? ◯ Yes ◯ No Does your jaws ever click or pop when chewing or opening?
- ◯ Yes ◯ No Do you clinch your teeth during the day or do you grind your teeth at night?
- ◯ Yes ◯ No Do you ever have earaches, ringing in the ears, or feel dizzy?
- ◯ Yes ◯ No Are any of your teeth sensitive to hot or cold? ◯ Yes ◯ No Do you have difficuly flossing between your teeth?
- ◯ Yes ◯ No Do you have crooked teeth or do you feel that your teeth stick out too far?
- ◯ Yes ◯ No Do you have spaces between your teeth that you do not like?

DESCRIBE ON ANOTHER PAGE TO TELL US ABOUT ANY DENTAL CONDITIONS NOT LISTED ON THIS FORM.

It is the responsibility of the patient to inform our office of any changes to your medical condition. Initial: ______

Signature ______ Date: ______