PATIENT MEDICAL HISTORY

1. Are you currently under medical treatment? **Y / N**
2. Have you ever been hospitalized for any surgical operation or serious illness? **Y / N**
3. Are you taking any medication(s) including non-prescription medicine?
   a) If yes, what medication(s) are you taking?
   ____
   ____
4. Do you use tobacco? **Y / N**
5. Do you use recreational drugs? **Y / N**
6. Do you drink alcohol? **Y / N**
   a) If Yes, How many per week ______
7. Are you wearing contact lenses? **Y / N**
8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) **Y / N**
9. Are you allergic to or have you had any reactions to the following:
   a) Local Anesthetics **Y / N**
   b) Aspirin **Y / N**
   c) Penicillin or other antibiotics **Y / N**
   d) Sedatives **Y / N**
   e) Sulfa Drugs **Y / N**
   f) Latex **Y / N**
   g) Other **Y / N**
10. Have you traveled out of the country in the last 6 months? **Y / N**
11. Women Only:
    a) Are you pregnant / may be pregnant? **Y / N**
    b) Are you nursing? **Y / N**
    c) Are you taking birth control pills? **Y / N**

12. Do you have or have you had any of the following? **Please check all that apply.**

- ◻ **NO TO ALL**
- ◻ Low / High Blood Pressure
- ◻ Heart Murmur
- ◻ Mitral Valve Prolapse
- ◻ Heart Disease
- ◻ Chest Pains
- ◻ Angina
- ◻ Heart Attack
- ◻ Cardiac Pacemaker
- ◻ Fainting / Seizures
- ◻ Epilepsy / Convulsions
- ◻ Stroke
- ◻ Tuberculosis
- ◻ Rheumatic Fever
- ◻ Emphysema
- ◻ Asthma
- ◻ Hay Fever / Allergies
- ◻ Anemia
- ◻ Leukemia
- ◻ Cancer
- ◻ Radiation Therapy
- ◻ Recent Weight Loss
- ◻ Thyroid Problem
- ◻ Diabetes
- ◻ Arthritis
- ◻ Joint Replacement
- ◻ Liver Disease
- ◻ Stomach Troubles / Ulcers
- ◻ AIDS or HIV Infection
- ◻ Sexually Transmitted Disease
- ◻ Other

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing/flossing? **Y / N**
2. Are your teeth sensitive to hot, cold, sweet, and/or sour liquids/foods? **Y / N**
3. Do you feel pain to any of your teeth? **Y / N**
4. Do you have any sores or lumps in or near your mouth? **Y / N**
5. Do you bite your lips or cheeks frequently? **Y / N**
6. Have you had any head, neck, or jaw injuries? **Y / N**
7. Do you have frequent headaches? **Y / N**
8. Do you clench or grind your teeth? **Y / N**
9. Have you ever experienced any of the following problems in your jaw?
   a) Clicking **Y / N**
   b) Pain **Y / N**
   c) Difficulty in opening or closing **Y / N**
   d) Difficulty in chewing **Y / N**
10. Have you had any Orthodontic treatment? **Y / N**
11. Have you had difficult extractions in the past? **Y / N**
12. Have you ever had prolonged bleeding following extractions? **Y / N**

Is there any other information about your health which we should know? ______________________________________

To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to dental treatment. I understand the privacy practices of this office. I authorize the release of any information to all my insurance carriers. I assign insurance benefits payable to the attending dentist. I understand the financial policy of this office. I understand I am responsible for my bill.

SIGNATURE:______________________________ **DATE:**______________
(Patient, Parent or Guardian)

REVIEWED BY THE ATTENDING DENTIST __________________ **DATE:**______________