

# Patient Medical/Dental History

Physician Name: \_\_\_\_\_

Date of last Medical Exam: \_\_\_\_\_

## Medical Information

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you under medical treatment now? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any Surgical operation or serious illness? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____  |                          |                          |
| 3. Are you taking any medication(s), including any non-prescription medicine? _____     | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____  |                          |                          |
| 4. Have you ever taken Phen-Fen/Redux? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have history of drug use? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have history of alcoholism? _____   | <input type="checkbox"/> | <input type="checkbox"/> |

## Allergy Information

1. Are you allergic to or have you had any reactions to any of the following? Yes No
- |   |                          |                          |
|---|--------------------------|--------------------------|
| - Local Anesthetic (e.g. Novocain) _____        | <input type="checkbox"/> | <input type="checkbox"/> |
| - Penicillin or other Antibiotics _____         | <input type="checkbox"/> | <input type="checkbox"/> |
| - Sulfa Drugs _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| - Barbiturates _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| - Sedatives _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| - Iodine _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| - Aspirin _____                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| - Any Metals (e.g. nickel, mercury, etc.) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Latex Rubber _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| - Other (please list) _____                     | <input type="checkbox"/> | <input type="checkbox"/> |
2. Women Only:
- a) Are you pregnant or think you may be pregnant? Yes No
- \_\_\_\_\_
- b) Are you nursing? Yes No
- \_\_\_\_\_
- c) Are you taking oral contraceptives? Yes No
- \_\_\_\_\_
- Antibiotics may stop the effectiveness of Birth Control Pills**

## Medical History

1. Do you have or have you had any of the following?
- |                               | Yes                      | No                       |                                     | Yes                      | No                       |   | Yes                      | No                       |
|-------------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| High Blood Pressure _____     | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease _____                 | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains _____                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack _____            | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker _____             | <input type="checkbox"/> | <input type="checkbox"/> | Stroke _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever _____         | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur _____                  | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies _____                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of limbs _____       | <input type="checkbox"/> | <input type="checkbox"/> | Angina _____                        | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis _____                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures _____       | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired _____              | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma _____                  | <input type="checkbox"/> | <input type="checkbox"/> | Anemia _____                        | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure _____      | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema _____                     | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss _____                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions _____    | <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____                        | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease _____                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia _____                | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____                     | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble _____                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes _____                | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement _____             | <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problems _____                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases _____         | <input type="checkbox"/> | <input type="checkbox"/> | Joint Implant _____                 | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse _____               | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV _____             | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice _____            | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea _____                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem _____         | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Diseases _____ | <input type="checkbox"/> | <input type="checkbox"/> | Blood Diseases/coagulation disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Malignant Hyper-thermia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia _____            | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis Medication _____             | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia _____            | <input type="checkbox"/> | <input type="checkbox"/> | Other _____                         | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

## Dental History

Name of previous Dentist and location: \_\_\_\_\_

Date of last Exam: \_\_\_\_\_

- |   | Yes                      | No                       |   | Yes                      | No                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? _____                 | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? _____         | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? _____       | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? _____                         | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? _____          | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? _____                   | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? |                          |                          | 14. Do you wear dentures or partials? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking? _____   | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement _____   |                          |                          |
| Pain (joint, ear, side of face)? _____                                  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions Regarding the care of your teeth and gums? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing? _____                                 | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? _____   | <input type="checkbox"/> | <input type="checkbox"/> |

## Authorization and Release

I certify that I have read and understand the above information 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 authorize the oral surgeon to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health/dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the oral surgeon insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
Signature of patient (or parent if minor)

Doctor Comments \_\_\_\_\_