Patient Medical/Dental History

Physician Name:_____ Date of last Medical Exam:_____

Medical Information

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

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)	☐	☐
- Penicillin or other Antibiotics	☐	☐
- Sulfa Drugs	☐	☐
- Barbiturates	☐	☐
- Sedatives	☐	☐
- Iodine	☐	☐
- Aspirin	☐	☐
- Any Metals (e.g. nickel, mercury, etc.)	☐	☐
- Latex Rubber	☐	☐
- Other (please list)	☐	☐

2. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Hay Fever/Allergies	☐	☐
Swelling of limbs	☐	☐	Angina	☐	☐	Tuberculosis	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Recent Weight Loss	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Heart Trouble	☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Breathing Problems	☐	☐
Kidney Diseases	☐	☐	Joint Implant	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV	☐	☐	Hepatitis/Jaundice	☐	☐	Sleep Apnea	☐	☐
Thyroid Problem	☐	☐	Sexually Transmitted Diseases	☐	☐	Blood Diseases/coagulation disorder	☐	☐
Malignant Hyper-thermia	☐	☐	Sickle Cell Anemia	☐	☐	Osteoporosis Medication	☐	☐
Fibromyalgia	☐	☐	Other	☐	☐			

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?	☐	☐	8. Do you have frequent headaches?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	9. Do you clench or grind your teeth?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	10. Do you bite your lips or cheeks frequently?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐	11. Have you ever had any difficult extractions in the past?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐	12. Have you ever had any prolonged bleeding following extractions?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐	13. Have you had any orthodontic treatment?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials?	☐	☐
			If yes, date of placement_____		
Clicking?	☐	☐	15. Have you ever received oral hygiene instructions		
Pain (joint, ear, side of face)?	☐	☐	Regarding the care of your teeth and gums?	☐	☐
Difficulty in opening or closing?	☐	☐	16. Do you like your smile?	☐	☐

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_____

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