

PATIENT HISTORY & INFORMATION

MEDICAL HISTORY

Patient's name: _____

Physician's name: _____ City/State: _____ Phone: _____

When was your last physical examination? _____ Results: _____

Have you been a patient in a hospital in the past 5 years: Yes No Reason: _____

Have you had any serious illness or operations? Yes No Type: _____

Do you have, or have you ever had, any of the following (Please check and describe fully under remarks):

- | | Yes | No | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | 14. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | 29. Ringing in the Ears | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | 15. Night Sweats | <input type="checkbox"/> | <input type="checkbox"/> | 30. Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Blood Disorder – Anemia | <input type="checkbox"/> | <input type="checkbox"/> | 16. Persistent Cough..... | <input type="checkbox"/> | <input type="checkbox"/> | a. Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Artificial Joints or Devices | <input type="checkbox"/> | <input type="checkbox"/> | 17. Tumor History | <input type="checkbox"/> | <input type="checkbox"/> | b. Other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Date: _____ | | | 18. Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | c. Codeine, Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> | 19. Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> | d. Local Aneshtetic, Novacain | <input type="checkbox"/> | <input type="checkbox"/> |
| Date: _____ | | | 20. Immune System Disorders | <input type="checkbox"/> | <input type="checkbox"/> | e. Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | 21. AIDS, ARC or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | f. Others | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Thyroid Disease, Hyperthyroidism | <input type="checkbox"/> | <input type="checkbox"/> | 22. Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> | 31. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | 23. Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> | 32. Tuberculosis, Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | 24. Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | 33. Do you Smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> | 25. Liver or Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | 34. Are you Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Fainting | <input type="checkbox"/> | <input type="checkbox"/> | 26. Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you taken Phen-Fen or Redux? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Persistent Swollen Glands | <input type="checkbox"/> | <input type="checkbox"/> | 27. Hepatitis, A, B or C | <input type="checkbox"/> | <input type="checkbox"/> | 36. Do you have skin reactions to metal jewelry? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Psychiatric Treatment | <input type="checkbox"/> | <input type="checkbox"/> | 28. Chronic Headaches | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Have you had excessive bleeding requiring treatment? Yes No

Taking any medicines, drugs or pills? Yes No If yes, what? _____

Have any disease or problem not listed above? _____

DENTAL HISTORY

- Are you satisfied with the appearance of your teeth and smile? Yes No
- Do your gums bleed when you brush?
- Do you feel that you can chew properly and without pain?
- Have you had orthodontic treatment?
- Have you ever had gum surgery?
- Have you had dental implants placed?
- Have you been told that you snore?
- Do you have a problem with bad breath?
- Are you aware of grinding your teeth?
- Do you feel anxiety about coming to the Dentist?
- Are you taking any medication for osteoporosis?
- Have you experienced any unfavorable reactions to previous dental treatment?
- Name of former dentist: _____ Phone _____ Date of last exam: _____
- Please note any special dental concerns that bring you to our office: _____

Patient Signature _____ Date: _____

Doctor's Signature _____ Date: _____