PATIENT INFORMATION
MEDICAL HISTORY

Patient Name:_____Date:_____
Last First MI (Preferred Name)
If minor, Parent's Name:_____
Employer:_____Occupation_____Gender:_____Family Status_____
Social Security:_____Birth Date:_____Age:_____
Address:_____
Street Apartment #
_____
City State Zip Code
Whom may we thank for referring you?_____ Driv. Lic. #_____
Phone (Home):_____(Work):_____(Cell):_____
Email (we can confirm appointments through email):_____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name_____
   Address _____
2. Are you under a physician's care?_____ YES NO
   Since when_____Why_____
3. When was your last complete physical exam?_____
4. Are you taking any medications or supplements?_____ YES NO
   (If yes, please list them at the end of this section)
5. Have you ever taken street/recreational drugs?:…… YES NO
6. Are you allergic to any medications or substances?..... YES NO
7. Do you have any other allergies?..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?..... YES NO
9. Are you sensitive to any metals or latex?……. YES NO
10. Are you pregnant or suspect you may be?..... YES NO
11. Do you use any birth control medications?..... YES NO
12. Have you ever been treated for or been told you might have heart disease?..... YES NO
13. Do you have a pace maker or an artificial heart valve implant?..... YES NO
14. Have you ever had rheumatic fever?..... YES NO
15. Are you aware of any heart murmurs?..... YES NO
16. Do you have high or low blood pressure?..... YES NO
17. Have you ever had a serious illness or major surgery?..... YES NO
    If so, explain_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?..... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism?..... YES NO
20. Do you have any artificial joints/prosthesis?..... YES NO
21. Do you have any blood disorders, such as anemia, leukemia or hemophilia?... YES NO
22. Have you ever bled excessively after being cut or injured?..... YES NO
23. Do you have any stomach problems?..... YES NO
24. Do you have any kidney problems?..... YES NO
25. Do you have any liver problems?..... YES NO
26. Are you diabetic?..... YES NO
27. Do you have asthma?..... YES NO
28. Do you have epilepsy or seizure disorders?..... YES NO
29. Do you or have you had a venereal disease?..... YES NO
30. Have you tested HIV positive?..... YES NO

COMMENTS

Medical History Continued

COMMENTS

31. Do you have AIDS?..... YES NO
32. Have you had or do you test positive for hepatitis?..... YES NO
33. Do you or have you had T.B…… YES NO
34. Do you smoke, chew, use snuff or any other form of tobacco?..... YES NO
35. Do you consume alcoholic beverages?..... YES NO
36. Have you had psychiatric treatment?..... YES NO
37. Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux) or other weight loss products?...YES NO
38. Do you have a fever, weight loss, night sweats, blood in the sputum, anorexia?..... YES NO
    If so, explain_____
39. Is there anything else we should know about your health that we have not covered in this form?_____
40. Would you like to speak to the Doctor privately about any problem?.....YES NO

List of Medications:

Name of Medicine*:** ***Condition Being Treated:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

DENTAL HISTORY

Patient's Name_____
Last First Initial Date of Birth

1. Purpose of initial visit_____
2. Are you aware of a problem?_____
3. How long since your last dental visit?_____
4. What was done at that time?_____
5. Previous dentist's name_____
6. When was the last time your teeth were cleaned?_____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

7. Have you made regular visits?..... YES NO
8. Were dental x-rays taken?..... YES NO
9. Have you lost any teeth or have any teeth been removed?..... YES NO
   Why?_____
10. Have they been replaced?..... YES NO
11. How have they been replaced?
    a. Fixed bridge_____ Age _____
    b. Removable bridge_____ Age _____
    c. Denture_____ Age _____
12. Are you unhappy with the replacement?..... . YES NO
    If yes, explain_____
13. Would you like to know about permanent replacements?_____ YES NO
14. Have you had any complications with previous dental treatments?..... YES NO
    If yes, explain_____
15. Do you clench or grind your teeth?..... YES NO
16. Does you jaw click or pop?..... YES NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear?..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches?..... YES NO
19. Does food get caught in your teeth?..... YES NO
20. Are any of your teeth sensitive to: □ Hot □ Cold □ Sweets □Pressure
21. Do your gums bleed or hurt?.....YES NO
    When?_____
22. How often do you brush your teeth?_____When?_____
23. Do you use dental floss?..... YES NO
    How often?_____
24. Are any of your teeth loose, tipped, shifted or chipped?_____ YES NO
25. Are you unhappy with the appearance of your teeth?_____ YES NO
26. How do you feel about your teeth in general?.....
27. Do you feel your breath is offensive at times?.....YES NO
28. Have you ever had gum treatment or surgery?.....YES NO
29. Have you had any orthodontic work?.....YES NO
30. Have you had any unpleasant dental experiences or is there anything about Dentistry that you strongly dislike?_____
31. Do you have any questions or concerns?..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's/Guardian's Signature_____Date:_____

Dentist's Signature:_____Date:_____

COMMENTS