

**PATIENT MEDICAL INFORMATION**      **Patient Name** \_\_\_\_\_

Name of Physician \_\_\_\_\_ Telephone # \_\_\_\_\_ Last Exam \_\_\_\_\_

Are you under medical care at this time? \_\_\_\_\_

**(If yes to any of the following please explain)**

Have you been hospitalized within the last 5 years? \_\_\_\_\_

Are you taking any medications, including non-prescribed medications? \_\_\_\_\_

Are you wearing contact lenses? \_\_\_\_\_ Do you use any controlled substances? \_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_ What type? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever taken Phen-Fen/Redux? \_\_\_\_\_ When? \_\_\_\_\_ For how Long? \_\_\_\_\_

Are you or have you ever taken? Fosamax \_\_\_\_\_ Actenol \_\_\_\_\_ Zometa \_\_\_\_\_ Aredia \_\_\_\_\_ Boniva \_\_\_\_\_

**WOMEN ONLY:** Are you pregnant? (or think you may be) \_\_\_\_\_ How far along are you? \_\_\_\_\_

Are you nursing? \_\_\_\_\_ Are you taking oral contraceptives? \_\_\_\_\_

**ALLERGIES: Are you allergic or have any reaction to the following:**

Local Anesthetic (Novocain) \_\_\_\_\_ Penicillin or any other Antibiotics \_\_\_\_\_

Latex Rubber \_\_\_\_\_ Aspirin \_\_\_\_\_ Barbituates \_\_\_\_\_ Sedatives \_\_\_\_\_ Sulfa Drugs \_\_\_\_\_ Codeine \_\_\_\_\_

Any Metals (Nickel, mercury, etc) \_\_\_\_\_ other \_\_\_\_\_

**HAVE YOU HAD ANY OF THE FOLLOWING: Please check those that apply**

- |                        |                           |                                   |
|------------------------|---------------------------|-----------------------------------|
| ___ AIDS               | ___ Glaucoma              | ___ Radiation Treatment           |
| ___ Anemia             | ___ Heart Murmur          | ___ Respiratory Problems          |
| ___ Arthritis          | ___ Heart Disease         | ___ Rheumatic Fever               |
| ___ Artificial Joints  | ___ Head Injuries         | ___ Rheumatism                    |
| ___ Asthma             | ___ Hepatitis             | ___ Sinus Problems                |
| ___ Angina             | ___ High Blood Pressure   | ___ Stomach Problems/Ulcers       |
| ___ Cancer             | ___ Heart Attack          | ___ Stroke                        |
| ___ Cardiac Pacemaker  | ___ Jaundice              | ___ Sexually Transmitted Diseases |
| ___ Chest Pains        | ___ Kidney Disease        | ___ Tuberculosis                  |
| ___ Diabetes           | ___ Leukemia              | ___ Tumors                        |
| ___ Dizziness          | ___ Low Blood Pressure    | ___ Thyroid Problems              |
| ___ Epilepsy           | ___ Liver Disease         | Other: _____                      |
| ___ Excessive Bleeding | ___ Mental Disorders      | _____                             |
| ___ Emphysema          | ___ Mitral Prolapse Valve | _____                             |
| ___ Fainting           | ___ Nervous Disorders     | _____                             |

**DENTAL HISTORY:**

- |  |  |
|--|--|
| 1. Do you bleed while brushing or flossing? _____          | 7. Do you bite your lips or cheeks frequently? _____ |
| 2. Are your teeth sensitive to temperature? _____          | 8. Do you wear dentures or partials? _____           |
| 3. Are your teeth sensitive to sweets? _____               | 9. Are you nervous about dental treatment? _____     |
| 4. Do you feel pain on any of your teeth? _____            | 10. Do you have difficulty chewing? _____            |
| 5. Do you have any sores in or near your mouth? _____      | 11. Have you ever had orthodontic treatment? _____   |
| 6. Have you ever had any head, neck or jaw injuries? _____ | 12. Do you like your smile? _____                    |

I certify that to the best of my knowledge the information provided is accurate and correct. It is my responsibility to notify my doctor in case of any changes in my health history. I give consent for treatment.

\_\_\_\_\_  
Patient (Guardian if under age 18)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date