Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you could be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	Please explain
Are you under a physicians care now?	☐	☐	________________
Have you ever been hospitalized or had a major operation?	☐	☐	________________
Have you ever has a serious head or neck injury?	☐	☐	________________
Do you use tobacco?	☐	☐	________________
Do you use controlled substances?	☐	☐	________________

Women: Are you ☐Pregnant/trying to get pregnant ☐Nursing? ☐Taking oral contraceptives?

Are you allergic to any of the following?

☐Asprin ☐Metal ☐Penicillin ☐Latex ☐Codeine

☐Acrylic ☐Local Anesthetics ☐Other ________________

Do you have or have you had any of the following?

☐High Blood Pressure	☐Heart Disease	☐Chest Pains	☐Easily Winded	☐Rheumatic Fever
☐Heart Attack	☐Cardiac Pacemaker	☐Heart Murmur	☐Stroke	☐Swollen Ankles
☐Angina	☐Hay Fever/Allergies	☐Fainting/Seizures	☐Frequently Tires	☐Tuberculosis
☐Asthma	☐Anemia	☐Radiation Therapy	☐Low Blood Pressure	☐Emphysema
☐Glaucoma	☐Epilepsy/Convulsions	☐Cancer	☐Recent Weight Loss	☐Leukemia
☐Arthritis	☐Liver Disease	☐Diabetes	☐Heart Trouble	☐Joint Replacement
☐Kidney Disease	☐Hepatitis/Jaundice	☐Respiratory Problems	☐AIDS/HIV Infection	☐Sexually Transmitted Disease
☐Mitral Valve Prolapse	☐Thyroid Problem	☐Stomach Troubles/Ulcer	☐Other________________	

Patient Dental History

Name of Previous Dentist________________ Date of Last Exam________________

Previous Dentist Location________________ Date of Last Cleaning________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sens.to hot/cold liquids/food?	☐	☐
3. Are your teeth sens.to sweet/sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you ever had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following Problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Doctor's Signature ________________ Date ________________