



Patient Medical and Dental History

YES NO

Medical History

1. Have you ever had a Serious Illness or Operation? (Please list)
2. Are you presently under the care of a physician?
3. Are you taking, or in the past 6 months had been taking any medications, herbals or non-prescription medications? (Please list)
4. Have you ever had an allergic reaction to Penicillin, Sulfonamides (Sulfa Drugs), Codeine, Aspirin, Latex or any other medications or chemicals?
5. Do you, or have you ever had High or Low Blood Pressure? Blood Disorders or Bleeding Problems?
6. Do you, or have you ever had a Heart Attack, Stroke, Heart Murmur or Heart Troubles?
Heart Attack Stroke Heart Murmur Heart Troubles
7. Have you ever had rheumatic fever, or infective endocarditis?
Rheumatic fever Infective endocarditis
8. Have you ever been diagnosed with Diabetes? Do you or have you ever had any Thyroid Disorders?
9. Do you, or have you ever had Epilepsy, Seizures, Nervous Disorders, Fainting Spells, or Frequent Headaches?
Epilepsy Seizures Nervous Disorders Fainting Spells Frequent Headaches
10. Have you ever been diagnosed with cancer?
11. Do you, or have you had Asthma, Tuberculosis, Lung Disease or Shortness of Breath?
Asthma Tuberculosis Lung Disease Shortness of Breath
12. Do you or have you ever had Ulcers, Jaundice, Gastrointestinal (stomach) problems or Liver Disease?
13. Is there any family history of disease? If so, what
14. Are you a smoker? If so, how much per day
15. WOMEN: Are you pregnant or breastfeeding?
16. Do you, or have you ever been diagnosed with HIV, AIDS, Hepatitis or other Blood Borne Diseases?
17. Is there any other information regarding your health which was not covered above?

YES NO

Dental History

18. What dental condition concerns you at present?
19. When was your last visit to the dentist? Your last cleaning?
20. Do you have any sore, aching, sensitive or loose teeth?
21. Do you or have you ever had any jaw joint (TMJ) problems, or any oral habits such as clenching, grinding or nail biting?
22. Do you or have you ever had an occlusal splint (night guard)?
23. Are you happy with the appearance of your teeth?

Thank you for taking the time to fill out our questionnaire. To whom should we thank for referring you here?

CONSENT: I hereby authorize the dental personnel to perform services for the prevention and treatment of dental disease using the procedures and medications required, and assume responsibility for the fees associated with these procedures.

(Signature of Patient/ Parent/Guardian)

Date: