Patient Medical and Dental History

Medical History

Yes No Question:

( ) ( ) 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? (Circle)

( ) ( ) 7.Have you ever had rheumatic fever, or infective endocarditis? (Circle)

( ) ( ) 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? (Circle)

( ) ( ) 10. Have you ever been diagnosed with cancer?

( ) ( ) 11. Do you or have you had Asthma, Tuberculosis, Lung Disease or Shortness of Breath? (Circle)

( ) ( ) 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? _____

( ) ( ) 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?
_____

Dental History

( ) ( ) 18. What dental condition concerns you at present? _____

( ) ( ) 19. When was your last visit to the dentist? _____

( ) ( ) 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. Who may we thank for referring you here?_____

Information regarding personal and family health history, physical condition and former dental treatment is collected for the purposes of properly diagnosing dental conditions and providing appropriate dental treatment.

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: _____