MEDICAL - DENTAL HISTORY

PATIENT NAME _____ AGE _____ DATE _____

CHECK YES OR NO

PATIENT MEDICAL HISTORY

☐ YES ☐ NO Are you under any Medical treatment now?
☐ YES ☐ NO Have you had any major operations? If so, what? _____
☐ YES ☐ NO Have you ever had a serious accident involving head or jaw injuries?
☐ YES ☐ NO Have you had any adverse response to any drugs including penicillin and aspirin?
☐ YES ☐ NO Have you ever had any of the following?

- ☐ Heart Ailment
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Respiratory Disease
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Rheumatism or Arthritis
- ☐ Tumors or Growths
- ☐ Any Blood Disease
- ☐ Any Liver Disease
- ☐ Any Kidney Disease
- ☐ Any Stomach or Intestinal Disease
- ☐ Any Venereal Disease
- ☐ Yellow Jaundice or Hepatitis
- ☐ Epilepsy
- ☐ AIDS

☐ YES ☐ NO Are you on a diet at this time?
☐ YES ☐ NO Are you now taking drugs or medications?
☐ YES ☐ NO Are you allergic to any known materials resulting in - hives, asthma, eczema, etc?
☐ YES ☐ NO Do you have any reason to suspect you are not in good health?
☐ YES ☐ NO Have any wounds healed slowly or presented other complications?
☐ YES ☐ NO Are you pregnant?
☐ YES ☐ NO Do you have a history of fainting?
☐ YES ☐ NO Have you ever had any X-RAY TREATMENTS (other than diagnostic)?
☐ YES ☐ NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?
☐ YES ☐ NO Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
☐ YES ☐ NO Have you ever taken Fen-Phen/Redux?
☐ YES ☐ NO Do you have a history of Tuberculosis?

PATIENT DENTAL HISTORY

☐ YES ☐NO Do you have any specific problems?
☐ YES ☐NO Do you have pain in or near your ears?
☐ YES ☐NO Do you have any unhealed injuries or inflamed areas in or around your mouth?
☐ YES ☐NO Have you experienced any growth or sore spots in your mouth?
☐ YES ☐NO Does any part of your mouth hurt when clenched?
☐ YES ☐NO Have you ever had Novocaine anesthetic?
☐ YES ☐NO Any reactions or allergic symptoms to novocaine?
☐ YES ☐NO Any difficult extractions in the past?
☐ YES ☐NO Have you had prolonged bleeding following extractions in the past?
☐ YES ☐NO Do your gums bleed?
☐ YES ☐NO Have you ever been instructed on the correct method of brushing your teeth?
☐ YES ☐NO Have you ever been instructed on the care of your gums?
☐ YES ☐NO Do you chew on only one side of your mouth?
☐ YES ☐NO Do you habitually clench your teeth during the night or day?
☐ YES ☐NO When was your last full mouth X-RAY taken? _____
Where? _____
☐ YES ☐NO Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)?
If so, locate _____

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____

Date _____

RECERTIFICATION: I certify that there have been no changes in my health except as noted below.

Date	Change	Signature

CURRENT MEDICATION	REASON

PATIENT'S NAME

MEDICAL / DENTAL HISTORY

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