

Patient Medical History

Name _____

Physician _____ Phone _____ Date of Last Exam _____

Are you under medical treatment now? Y N If so explain: _____

Are you taking any medication? Y N If so please list: _____

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

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions																																							
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems																																							
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis																																							
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers																																							
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Vonereal Disease																																							
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice																																							
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Pain In Jaw Joints																																							
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<table border="1"> <thead> <tr> <th>Y</th> <th>N</th> <th>Allergies</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Aspirin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Codeine</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dental Anesthetics</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Erythromycin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Jewelry</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Latex</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Metals</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Penicillin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tetracycline</td> </tr> <tr> <td colspan="2"></td> <td>Other</td> </tr> <tr> <td colspan="2"></td> <td>_____</td> </tr> <tr> <td colspan="2"></td> <td>_____</td> </tr> </tbody> </table>			Y	N	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline			Other			_____			_____
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<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS																																										
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems																																										
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																																										
<input type="checkbox"/>	<input type="checkbox"/>	Cancer- Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure																																										
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse																																										
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker																																										
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis																																										
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems																																										
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy																																										
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever																																										
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Selzures																																										
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Shingles																																										
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease																																										
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems																																										
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke																																										

If female please answer the following:

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If Yes, # of weeks <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?

Please answer the following:

Y	N		
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or use tobacco?	Height: <input type="text"/>
For Office Use Only		BP: <input type="text"/>	Heart Rate: <input type="text"/>
			Weight: <input type="text"/>

Please let our office know if there is a condition not covered by any of the above.

Dental History

Previous Dentist _____ Phone _____ Date of Last Exam _____

Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to:	
Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Hot Cold Sweet Sour	<input type="checkbox"/>
Do you have sores or lumps in or near mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind teeth?	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or checks often?	<input type="checkbox"/>
Have you had any difficult extractions?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>
Have you ever received oral hygiene instructions?	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?	<input type="checkbox"/>