PATIENT MEDICAL HISTORY

Today's Date______________

Patient Name: ____ Date of Birth__________________ Sex: M F
By what name do you prefer to be called? ____
Height_______ Weight_______ Emergency Contact _________________________________ Phone: _______________
If you are completing this form for another person, what is your relationship to that person? __________________________
Primary Care Physician: ______________________________ Phone #: _________________ Date of Last Exam: ________

Yes NO
___ ___ Are you under medical treatment now? Why: ____
___ ___ Have you been hospitalized in the past 5 years? Why?: ____________________________________
___ ___ Has there been any change in your general health in the past year? ___________________________________

Please list any medications you are currently taking ____
____
Please list any known allergies including latex: ____

Have you ever been told you have one of the following? ***Check only if answer is yes.***
___Diabetes- if yes, answer questions below:
-Do you take insulin? _______________________________
-Do you monitor your blood sugar? ___ What have the numbers been lately? ____ Hemoglobin A1C (if known)______
___Heart Attack- if yes, answer questions below:
- Have you ever had a stent placed due to blood vessel blockages? ______ When?______________

___ Heart Disease
___ Abnormal Heart Rhythm
___ Heart Murmur
___ Chest Pain/Angina
___ Congenital Heart Defect
___ Rheumatic Fever
___ High Blood Pressure
___ Low Blood Pressure
___ Stroke-When?______________________
___ Damaged Heart Valve/Endocarditis
___ Artificial Heart Valve
___ Pacemaker
___ Atherosclerosis/Arteriosclerosis
___ Sexually Transmitted Disease

___ Anemia
___ Bleeds Easily
___ Fainting/Seizures
___ Epilepsy/ Convulsions
___ Diseases of the Immune System
___ Joint Replacement-When?_______
___ Liver Disease
___ Hepatitis
___ Jaundice
___ Glaucoma
___ Leukemia
___ AIDS/HIV
___ Kidney Disease
___ Asthma-Have an inhaler? ____

___ Arthritis
___ Shortness of Breath
___ Swollen Ankles
___ Hay Fever/Allergies
___ Emphysema/COPD
___ Recent Weight Loss
___ Tuberculosis
___ Cancer
___ Radiation Therapy
___ Psychiatric Treatment
___ Thyroid Disease
___ Reflux/Stomach Ulcer
___ Anorexia
___ Bulimia

Yes NO
___ ___ Have you ever taken medications for osteoporosis or bone cancer in the past?______________________________
___ ___ Do you use tobacco? What type and for how long?____
___ ___ Do you use Alcohol, Cocaine or other drugs? What: ____
___ ___ Women Only: Are you pregnant or think you may be pregnant? What month:_____________________________
Are you taking birth control pills?_______
Are you nursing? ___________
Do you have any disease, condition, or problem not listed above that you think we should know about? _________________
____

(continue on to page 2 on back)

OFFICE USE ONLY Medical History Update

Date	Comments/Changes	Signature
__________	____	___________________
__________	____	___________________
__________	____	___________________
__________	____	___________________

PATIENT DENTAL HISTORY

What is your reason for seeking care at this time: ____
Do you have regular dental checkups? When was your last dental exam: ______________________________
Do you have any pain or discomfort now? What: ____
Do your gums bleed? ______________________
Have you ever been diagnosed with periodontal disease or gingivitis? ___________________________________
Have you had surgery performed on your gums? ___________________
Have you ever had a root canal? ____________
Have you ever worn braces? ___________
Do you wear dentures or partial dentures?__________
Are you interested in replacing lost or missing teeth? ________________________
Do you grind your teeth? _____________
Have you ever had any trauma to your face or mouth? _______________________
Do you floss? How often _______________
How many times a day do you brush your teeth? _______________________
What kind of toothpaste do you use? ___________________________
Are you interested in making your teeth whiter? ______________________
Are you interested in improving the appearance of your smile? _________________
Do you tend to get anxious at the dentist? ____________________________
Have you had any serious trouble associated with previous dental treatment? _______________________________________
____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____ Date: ______________________
Signature of Patient/Parent or Guardian

To be filled out by dentist/staff

Comments:____
____
____
____
____
____