

Patient Name _____ Telephone _____
Last First Date of BirthMedical Doctor's Name _____ Telephone _____
("y" for yes. "n" for no)Are you under physician's care? ☐ yes ☐ no If yes, explain _____Have you ever been hospitalized or had a major operation? ☐ yes ☐ no If yes, explain _____Have you ever had a serious head or neck injury? ☐ yes ☐ no If yes, explain _____Are you on a special diet? ☐ yes ☐ no If yes, explain _____Do you use tobacco? ☐ yes ☐ no Specify _____Do you use controlled substances? ☐ yes ☐ no Specify _____

Medications: _____

Woman: Are you: pregnant/trying to get pregnant? ☐ Nursing ☐ Taking Contraceptives? Specify _____Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

Other (please explain) _____

Have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever/ Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement/Implants	<input type="checkbox"/>	<input type="checkbox"/>			

Dental Questions:

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	7. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to heat/ cold/ sweets?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you bite you lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any sores or lumps in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever had difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever experienced any of the following problems in your jaw?			12. Have you ever had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (Joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever received oral hygiene instructions?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Medical Updates

Date Findings Reviewed by Date Findings Reviewed by

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____