

MEDICAL - DENTAL HISTORY

PATIENT NAME _____ BIRTHDATE _____

PATIENT MEDICAL HISTORY CHECK YES OR NO

- ☐ 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 | ☐ Any Blood Disease |
| ☐ High Blood Pressure | ☐ Any Liver Disease |
| ☐ Low Blood Pressure | ☐ Any Kidney Disease |
| ☐ Respiratory Disease | ☐ Any Stomach or Intestinal Disease |
| ☐ Diabetes | ☐ Any Venereal Disease |
| ☐ Rheumatic Fever | ☐ Yellow Jaundice or Hepatitis |
| ☐ Rheumatism or Arthritis | ☐ Epilepsy |
| ☐ Tumors or Growths | ☐ 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 been diagnosed with cancer?
- ☐ YES ☐ NO Have you ever had chemotherapy?
- ☐ YES ☐ NO Have you ever had radiation therapy?
- ☐ YES ☐ NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?
- ☐ YES ☐ NO Does your medical doctor recommend pre-medication before dental treatment?

PATIENT DENTAL HISTORY CHECK YES OR NO

- ☐ 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 anesthetics?
- ☐ 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 Have you had a full mouth X-RAY?
If so, when? _____
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

List additional medications on reverse side