Patient Medical History

Physician______________________ **Office Phone**_________________ **Date of Last Exam** ____/___/_____

	Yes	No
Are you under medical treatment now?	☐	☐
If yes, please explain______________________________		
Have you ever been hospitalized for a surgical operation or a serious illness?	☐	☐
If yes, please explain______________________________		
Are you taking any medication(s) including non-prescription medication?	☐	☐
If yes, please explain______________________________		

Do you use tobacco? ☐yes ☐ no Do you use Alcohol, Cocaine or other Drugs? ☐ yes ☐ no

Have you ever been diagnosed with sleep apnea? ☐ yes ☐ no Do you snore? ☐ yes ☐ no

Are you allergic to or have you had any reactions to any of the following: ☐ Local anesthetics ☐ Penicillin ☐ Antibiotics ☐ Sulfa Drugs ☐ Barbiturates ☐ Sedatives ☐ Iodine ☐ Aspirin ☐ other_____________

**Women Only: ☐ pregnant ☐ nursing ☐ taking birth control pills ☐ none ☐ other_____________

Do you have or have you been diagnosed with any of the following:

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐
Angina/Chest Pains	☐	☐	Hay Fever/Allergies	☐	☐	Osteoarthritis	☐	☐
Asthma	☐	☐	Head Trauma/Concussion	☐	☐	Radiation Therapy	☐	☐
AIDS/HIV Infection	☐	☐	Heart Attack	☐	☐	Recent Weight Loss	☐	☐
Bleeding Disorders	☐	☐	Heart Disease	☐	☐	Respiratory Problems	☐	☐
Cancer	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Cardiac Pacemaker	☐	☐	Hepatitis/Jaundice	☐	☐	Rheumatoid Arthritis	☐	☐
Chronic Fatigue Syndrome	☐	☐	High Blood Pressure	☐	☐	Seizures/Fainting	☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Sexually Transmitted Disease	☐	☐
Easily Winded	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐
Emphysema	☐	☐	Leukemia	☐	☐	Swollen Ankles	☐	☐
Epilepsy/Convulsions	☐	☐	Liver Disease	☐	☐	Thyroid Problem	☐	☐
Fibromyalgia	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
COVID-19	☐	☐						

Patient Dental History

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	☐	☐	Do you have frequent headaches?	☐	☐
Are your teeth sensitive to hot or cold liquids/food?	☐	☐	Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to sweet or sour foods?	☐	☐	Do you bite your lip or cheek frequentl	☐	☐
Do you have any sores or lumps in your mouth?	☐	☐	Have you had orthodontics?	☐	☐
Have you had difficult extractions in the past?	☐	☐	Any head, neck or jaw injuries?	☐	☐
Have you had prolonged bleeding following extractions?	☐	☐	Are any of your teeth loose?	☐	☐
Are you having pain or clicking in your jaw?	☐	☐	Difficulty opening or closing?	☐	☐
Have you been diagnosed with gum disease?	☐	☐	Have you had oral hygiene instructions	☐	☐

Are you having Dental Pain? ☐ yes ☐ no If yes, please explain____

Authorization and Release

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health professionals.

Signature of Patient or Parent ____ Date_____/_____/_________

Doctor's Signature____ Date_____/_____/_________