Patient Medical & Dental History

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Name:	Age:	Date:

MEDICAL HISTORY (CHECK YES OR NO)

- Are you under any Medical treatment now? . . . . . ☐ Yes ☐ No
- Have you had any major operations? . . . . . ☐ 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
- Check if you have or have ever had any of the following:

☐ Heart Ailment	☐ Rheumatism or Arthritis	☐ Any Stomach or Intestinal Disease	☐ Alcoholism
☐ High Blood Pressure	☐ Tumors or Growths	☐ Any Veneral Disease	☐ Drug Addicti
☐ Low Blood Pressure	☐ Any Blood Disease	☐ Yellow Jaundice or Hepatitis	☐ Past Drug Addictio
☐ Respiratory Disease	☐ Any Liver Disease	☐ Epilepsy	
☐ Diabetes	☐ Any Kidney Disease	☐ Aids	
☐ Rheumatic Fever	☐ Heart Murmur	☐ HIV Positive	

- 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 had any *X-RAY TREATMENTS* (other than diagnostic)? . . . . . ☐ Yes ☐ No
- Have you received any donor organs, artificial heart valves, vessels, joint implants (pins or artificial prosthetus) or use a pacemaker? . . . . . ☐ Yes ☐ No

Current Medications:	Reason:

DENTAL HISTORY (CHECK YES OR 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 Novacaine anesthetic? . . . . . ☐ Yes ☐ No
- Any reactions or allergic symptoms to nonovaine? . . . . . ☐ 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
- When was your last full mouth X-RAY taken? (Date: ________________)
- Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? . . . . . ☐ Yes ☐ No

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Patient's Signature:	Date:

RECERTIFICATION: I certify that there have been no changes in my health except as noted below:

Date	Change	Signature