PATIENT MEDICAL HISTORY

Patient Name (please print) ____
Physician ______________________ Office Phone ____________ Date of Last Physical Exam ________
Are you under medical treatment now? __________ Have you been in the last 2 years? ___________
Have you ever been hospitalized for any surgery or serious illness? ________________ When __________
Do you have or have you had any of the following conditions? **PLEASE CHECK ALL THAT APPLY**.

___Arthritis
___Asthma/Respiratory
___Bulimia/Anoxia
___Cancer
___Chest Pains
___Diabetes
___Epilepsy/Convulsions
___Fainting
___Hay Fever/Allergies
___Hepatitis/Jaundice
___High ___Low Blood Pressure

___Heart Attack/Surgery
___Heart Murmur
___Heart Disease/pacemaker
___Herpes Simplex I or II
___HIV Infection/Aids
___Kidney Disease
___Leukemia/Anemia/Blood disorder
___Glaucoma
___Take Bisphosphonates (e.g. Fosamax, Boniva, Actenol)
___Full/partial Joint Replacement Date of joint replacement/s________
___I have taken Fen-Phen

___Radiation/Chemotherapy
___Recreational Drug use
___Rheumatic Fever
___Stomach Problems
___Stroke
___Thyroid Problems
___Tuberculosis
___Wear contacts

Anything not mentioned above ____

Women only: Are you pregnant? __________ Are you taking birth control? ____________
Are you aware that antibiotics can decrease the effectiveness of birth control? __________

MEDICATIONS

Please list medications you are currently taking:

____
____
____

____ Not currently taking medication
Pharmacy Name: ________________

ALLERGIES

Have you had a reaction to any of the following?
(Please check if yes)

Aspirin/Ibuprofen____ Penicillin____
Codeine____ Sedatives____
Iodine ____ Sulfa____
Latex____ Local Anesthetic____
No known drug allergies____ Other ______________

PATIENT DENTAL HISTORY

When was your last dental visit? ________________ For what reason? ______________________
Who was your previous dentist? ________________ When were x-rays last taken? ______________

Yes	No	
____	____	Are you having pain/discomfort at this time?
____	____	Do your gums bleed when you brush?
____	____	Do you have a history of gum disease?
____	____	Have you had difficult extractions in the past?
____	____	Do you have any lumps in/near your mouth?
____	____	Have you had any head, neck or jaw injuries?

Yes	No	
____	____	Have you had any problems with your jaw?
____	____	Do you clench or grind your teeth?
____	____	Do you wear a denture, partial or retainer?
____	____	Have you had a bad dental experience?
____	____	Do you use tobacco products? Pack/day_____
____	____	Do you like your SMILE?

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 may be detrimental to my health.

Patient Signature______________________ Parent or Guardian______________________

Date______________________