

TODAY'S DATE _____

DATE OF BIRTH _____

HOME PHONE _____

CELL PHONE _____

BUSINESS PHONE _____

SS #/SIN _____

PATIENT NAME

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

1. Are you under medical treatment now? ☐ ☐
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ ☐
3. Are you taking any medication(s) including non-prescription medicine? ☐ ☐

If yes, what medication(s) are you taking? _____

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other
☐	☐	Sulfa Drugs	☐	☐	Iodine			

4. Have you ever taken Fen-Phen/Redux? ☐ ☐

5. Do you use tobacco? ☐ ☐

6. Do you use alcohol, cocaine or other drugs? ☐ ☐

7. Are you wearing contact lenses? ☐ ☐

9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?

YES NO

10/10

10. WOMEN ONLY:

a) Are you pregnant or think you may be pregnant?
b) Are you nursing?
c) Are you taking birth control pills?

11. Do you have or have you had any of the following?

YES NO

YES NO

YES NO

- ☐ ☐ High Blood Pressure
- ☐ ☐ Heart Attack
- ☒ ☐ Rheumatic Fever
- ☐ ☐ Swollen Ankles
- ☐ ☐ Fainting / Seizures
- ☐ ☐ Asthma
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Epilepsy / Convulsions
- ☐ ☐ Leukemia
- ☐ ☐ Diabetes
- ☐ ☐ Kidney Disease
- ☐ ☐ AIDS or HIV Infection
- ☐ ☐ Thyroid Problem

☐	☐	Heart Disease
☐	☐	Cardiac Pacemaker
☐	☐	Heart Murmur
☐	☐	Angina
☐	☐	Frequently Tired
☐	☐	Anemia
☐	☐	Emphysema
☐	☐	Cancer
☐	☐	Arthritis
☐	☐	Joint Replacement or Implants
☐	☐	Hepatitis / Jaundice
☐	☐	Sexually Transmitted Disease
☐	☐	Stomach Troubles / Ulcers

☐ ☐ Chest Pains
☐ ☐ Easily Winded
☐ ☐ Stroke
☐ ☐ Hay Fever / Allergies
☐ ☐ Tuberculosis
☐ ☐ Radiation Therapy
☐ ☐ Glaucoma
☐ ☐ Recent Weight Loss
☐ ☐ Liver Disease
☐ ☐ Heart Trouble
☐ ☐ Respiratory Problems
☐ ☐ Other _____

COMMENTS

Signature of Dentist _____

Date _____

YES NO

1. Do your gums bleed while brushing or flossing?
2. Are your teeth sensitive to hot or cold liquids/foods?
3. Are your teeth sensitive to sweet or sour liquids/foods?
4. Do you feel pain to any of your teeth?
5. Do you have any sores or lumps in or near your mouth?
6. Have you had any head, neck or jaw injuries?
7. Have you ever experienced any of the following problems in your jaw?
 - a) Clicking?
 - b) Pain (joint, ear, side of face)?
 - c) Difficulty in opening or closing?
 - d) Difficulty in chewing?

8. Do you have frequent headaches?
9. Do you clench or grind your teeth?
10. Do you bite your lips or cheeks frequently?
11. Have you ever had any difficult extractions in the past?
12. Have you had any orthodontic work?
13. Have you ever had prolonged bleeding following extractions?
14. Have you ever had instruction on the correct method of brushing your teeth?
15. Have you ever had instructions on the care of your gums?

YES NO

[illegible]

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.

SIGNATURE

X

PATIENT, PARENT OR GUARDIAN

DATE _____