Patient Medical History Physician Office Phone Date of Last Exam No No 1. Are you under medical treatment now?.... 10. Are you wearing contact lenses?..... 2. Have you ever been hospitalized for any 11. Are you allergic to or have you had any reactions to the following? surgical operation or serious illness within the last 5 years?..... Local Anesthetics (e.g. Novocain) Penicillin or any other Antibiotics If yes, please explain _____ Sulfa Drugs 3. Are you taking any medication(s) Barbiturates..... including non-prescription medicine? Sedatives. If yes, what medication(s) are you taking? Iodine Any Metals (e.g. nickel, mercury, etc.).... 4. Have you ever taken Fen-Phen/Redux? 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer Latex Rubber Other (please list) medications containing bisphosphonates?..... 12. Do you have a persistent cough or throat clearing not 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? associated with a known illness (lasting more than 3 weeks)?... 8. Do you use controlled substances? a) Are you pregnant or think you may be pregnant?...... b) Are you nursing?.... 9. Do you have or have you had any of the following? c) Are you taking oral contraceptives?.... High Blood Pressure..... Heart Disease Chest Pains.... Cardiac Pacemaker Easily Winded..... Heart Attack Rheumatic Fever Heart Murmur..... Stroke..... Angina..... Hay Fever / Allergies..... Swollen Ankles..... Frequently Tired..... Tuberculosis Fainting / Seizures Anemia..... Asthma.... Radiation Therapy..... Low Blood Pressure..... Emphysema Glaucoma..... Epilepsy / Convulsions..... Cancer..... Recent Weight Loss Leukemia..... Liver Disease Diabetes Joint Replacement or Implant...... Heart Trouble Respiratory Problems Kidney Diseases Hepatitis / Jaundice..... -Sexually Transmitted Disease Mitral Valve Prolapse AIDS or HIV Infection Thyroid Problem Stomach Troubles / Ulcers Patient Dental History Name of Previous Dentist and Location Date of Last Exam No No 8. Do you have frequent headaches?.... 1. Do your gums bleed while brushing or flossing?..... 2. Are your teeth sensitive to hot or cold liquids/foods?.... 9. Do you clench or grind your teeth?.... 3. Are your teeth sensitive to sweet or sour liquids/foods? 10. Do you bite your lips or cheeks frequently? 4. Do you feel pain to any of your teeth?..... 11. Have you ever had any difficult extractions 5. Do you have any sores or lumps in or near your mouth?..... in the past? 6. Have you had any head, neck or jaw injuries?..... 12. Have you ever had any prolonged bleeding 7. Have you ever experienced any of the following following extractions? 13. Have you had any orthodontic treatment?..... problems in your jaw? Clicking..... 14. Do you wear dentures or partials?..... Pain (joint, ear, side of face) If yes, date of placement 15. Have you ever received oral hygiene instructions Difficulty in opening or closing..... Difficulty in chewing regarding the care of your teeth and gums? 16. Do you like your smile? 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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Signature of patient (or parent/guardian if minor) Date Doctor's Comments __ gnature __