MEDICAL – DENTAL HISTORY

PATIENT NAME _____ AGE _____ DATE _____

CHECK YES OR NO

PATIENT MEDICAL HISTORY

- ☐ YES ☐ NO Are you under any Medical treatment now?
- ☐ YES ☐ NO Have you had any major operations? If so, what? _____
- ☐ 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 Have you ever had any of the following?
  - ☐ Heart Ailment
  - ☐ High Blood Pressure
  - ☐ Low Blood Pressure
  - ☐ Respiratory Disease
  - ☐ Diabetes
  - ☐ Rheumatic Fever
  - ☐ Rheumatism or Arthritis
  - ☐ Tumors or Growths
  - ☐ Any Blood Disease
  - ☐ Any Liver Disease
  - ☐ Any Kidney Disease
  - ☐ Any Stomach or Intestinal Disease
  - ☐ Any Venereal Disease
  - ☐ Yellow Jaundice or Hepatitis
  - ☐ Epilepsy
  - ☐ AIDS
- ☐ YES ☐ NO 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 <u>not</u> 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 or use a pacemaker?

PATIENT DENTAL HISTORY

- ☐ YES ☐ 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 Novocaine anesthetic?
- ☐ YES ☐ NO Any reactions or allergic symptoms to novocaine?
- ☐ 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? _____ Where? _____
- ☐ YES ☐ NO Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? If so, locate _____

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

Signature _____

Date _____

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

CURRENT MEDICATION	REASON

MEDICAL HISTORY UPDATE

DATE	CHANGES	SIGNATURE