

## Patient Information/Medical History Form

Name (Last/First) \_\_\_\_\_

Date \_\_\_\_\_

1. What is your primary dental concern? \_\_\_\_\_
2. When was your last dental cleaning? (mo/yr) \_\_\_\_ - \_\_\_\_      Your last set of X-Rays?(mo/yr) \_\_\_\_ - \_\_\_\_
3. Do you have any uncompleted dental treatments? \_\_\_\_\_
4. How satisfied are you with your smile?    Not at All    1    2    3    4    5    6    7    8    9    10    Very Satisfied
5. Do you have symptoms of gum disease (bleeding gums, sore gums, bad taste or odor in the mouth, loose teeth)?    Yes    No
6. Do you suffer from frequent migraine headaches or have problems with your Jaw Joint?    Yes    No
7. Do you or your significant other snore?    Yes    No

**For the following questions please circle all answers that apply, if none apply please check none.**

**Do you have, or have you ever had any of the following:**

Heart Murmur	Rheumatic Fever	Vascular Shunt	High Blood Pressure	Coronary Occlusion
Arteriosclerosis	Stroke	Heart Attack	Heart Defect	Artificial Heart Valves
Tuberculosis	AIDS/ HIV	Hepatitis A/B/C	Liver Problems	Kidney or Adrenal Problems
Sinus Trouble	Respiratory Problems	Diabetes	Hiatal Hernia	Neurological Problems
Digestive Problems	Colitis	Stomach Ulcer	Mental Health Problems	Abnormal Bleeding
Fainting	Seizures	Epilepsy	Cancer	Tumor(s)
Clotting Problems	Phlebitis	Anemia Transfusions	<b>Other:</b>	<b>None</b>
Arthritis	Artificial Joints	Muscle or Bone Disease		

**Are you allergic to any of the following:**

Penicillin	Sulfa/Antibiotics	Erythromycin	Local Anesthetics	<b>Other:</b>
Codeine	Nickel/Other Metals	Latex	<b>No Allergies</b>	

List any medications you are currently taking: \_\_\_\_\_

**Do you: Circle all that apply**

<b>Women:</b>	Smoke	Use Chewing Tobacco/Snuff	Drink Alcohol	<b>Other:</b>
	Take Birth Control	Pregnant	Nursing	<b>None</b>

Have you ever had Surgery:    Yes    No    Type of Surgery: \_\_\_\_\_      Date of Surgery: (mo/yr) \_\_\_\_ - \_\_\_\_

Have you been treated for any other conditions not on this form? \_\_\_\_\_

**I understand that this Patient Information/Medical History form is a legal document and that I have answered all of the above questions to the best of my ability and knowledge and I will not hold my dentist or any other staff member responsible for any errors or omissions I have made in the completion of this form.**

Signature of Patient or Legal Guardian \_\_\_\_\_      Date \_\_\_\_\_