Confidential Patient Information

Name: DOB:

These questions are for your benefits and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental concern, but they are all associated with proper oral health care. Please answer each question and mark YES or NO as appropriate.

MEDICAL HISTORY

		Yes	No
1.	Are you in good health?	□	□
2.	Are you now under the care of a physician?	□	□
	a. If so, what is the condition being treated? _____		
	b. Physician name/phone#/ address _____		
3.	Have you ever had any serious illness or operation?	□	□
	a. If so, what illness or operation? _____		
4.	Have you ever been hospitalized?	□	□
	a. If so, what was the problem? _____		
5.	Are you taking any medications? □ Yes □ No or any recreational drugs?	□	□
	a. If so, what medications/ dosage? _____		
6.	Are you sensitive or allergic to any drugs? □Penicillin □Tetracycline □Sulfa drugs □Aspirin □ Codeine	□	□
	a. Please list if any others; _____		

7. Do you have, or have had, any of the following:

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
□	□	Heart Murmur	□	□	Joint Replacement	□	□	Epilepsy or Seizures	□	□	Anemia	□	□	Liver Disease
□	□	High Blood Pressure	□	□	Allergies or Hives	□	□	Heart Ailments or Attack	□	□	Ulcers	□	□	Sinus Trouble
□	□	Radiation Therapy	□	□	Cortisone Medicine	□	□	Hepatitis or Jaundice	□	□	Glaucoma	□	□	Blood Disease
□	□	Rheumatic Fever	□	□	Excessive Bleeding	□	□	Fainting Spells	□	□	Arthritis	□	□	Drug Addiction
□	□	Tuberculosis (T.B.)	□	□	AIDS Related Complex	□	□	Chemotherapy (i.e. Cancer)	□	□	Emphysema	□	□	Kidney Disease
□	□	Cardiac Pacemaker	□	□	Pain in Jaw Joints	□	□	Venereal Disease	□	□	Cold Sores	□	□	A.I.D.S.
□	□	Nervous Disorders	□	□	Respiratory Disease	□	□	Artificial Prosthesis	□	□	Bruise Easily	□	□	Asthma
□	□	Thyroid Disease	□	□	Mental Disorder	□	□	Angina Pectoris	□	□	Head Injuries	□	□	Hemophilia
□	□	Tumors or growths	□	□	Psychiatric Treatment	□	□	Congenital Heart Lesions	□	□	Diabetes	□	□	Stroke
□	□	Blood Transfusion	□	□	Cerebral Palsy	□	□	Heart Surgery	□	□	Prosthetic Joints			

		Yes	No
8.	Do you have any disease, condition, or problem not listed that you think we should know about?	□	□
	a. If so, what? _____		
9.	Do you smoke?	□	□
	a. If yes, how much per day? _____		
10.	Are you currently taking, or have you ever taken the drug Phen-Phen?	□	□
11.	Are you or have you ever taken a Bisphosphonate (osteoporosis) medication?	□	□
12.	(Women) Is there a possibility you may be pregnant?	□	□
13.	(Women) Do you have any problems associated with your menstrual period?	□	□
14.	(Women) Do you take birth control pills?	□	□

DENTAL HISTORY

1.	Have you ever had a local anesthetic (Novocain, etc.)?	□	□	
2.	Have you ever had any unfavorable reaction from a local anesthetic?	□	□	
3.	Have you had any serious trouble associated with any previous dental treatment?	□	□	
4.	How long since your last full mouth x-rays? _____			
5.	How long since your last dental treatment? _____			
6.	Is any current dental problem the result of an accident?	□ YES □ NO	When?	
7.	Does dental treatment make you nervous?	□NO	□ Slightly	□ Moderately □Extremely

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To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Patient Signature: _____ Date: _____ DDS Signature: _____Date: _____
Year 2 change in health: _____ □ None
Patient Signature: _____ Date: _____ DDS Signature: _____Date: _____
Year 3 change in health: _____ □ None
Patient Signature: _____ Date: _____ DDS Signature: _____Date: _____

Blood Pressure: _____ _____ _____ _____ DDS Notes: _____
Date: _____ _____ _____ _____ _____