PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient legal name______________________________ Date of birth __________ Age ______

Nickname or what you prefer to be called ______________________________
Name of medical doctor ______________________________

Approximate date of last visit to medical doctor ______________________________

MEDICAL HEALTH HISTORY
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Heart Problems	Yes	No
Chest pain	❑	❑
Shortness of breath	❑	❑
Blood pressure problem	❑	❑
Heart murmur	❑	❑
Heart valve problem	❑	❑
Do you require pre-medication ❑ Yes ❑ No ❑ Don't know		
Taking heart medication	❑	❑
Rheumatic fever	❑	❑
Pacemaker	❑	❑
Artificial heart valve	❑	❑
Blood Problems	❑	❑
Easy bruising	❑	❑
Frequent nose bleeds	❑	❑
Abnormal bleeding	❑	❑
Blood disease (anemia)	❑	❑
Allergy Problems	❑	❑
Hay fever	❑	❑
Sinus problems	❑	❑
Skin rashes	❑	❑
Taking allergy medication	❑	❑
Asthma	❑	❑
Intestinal Problems	❑	❑
Ulcers	❑	❑
Weight gain or loss	❑	❑
Special diet	❑	❑
Constipation	❑	❑
Bone or Joint Problems	❑	❑
Arthritis	❑	❑
Back or neck pain	❑	❑
Joint replacement (e.g., knee, hip)	❑	❑
Do you require pre-medication ❑ Yes ❑ No ❑ Don't know		
Fainting Spells, Seizures, or Epilepsy	❑	❑
Are you allergic or have you reacted adversely to any of the following?		
Local anesthetics ("Novocaine")	❑	❑
Penicillin or other antibiotics	❑	❑
Sulfa drugs	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Aspirin	❑	❑
Codeine	❑	❑
Other	❑	❑
Other	❑	❑

	Yes	No
Urinate more than 6 times a day	❑	❑
Thirsty or mouth is dry much of the time	❑	❑
Family history of diabetes	❑	❑
Tuberculosis or other respiratory disease	❑	❑
Cancer/Tumor	❑	❑
Do You Drink	❑	❑
If so, how much?	❑	❑
Do You Smoke?	❑	❑
If so, how much?	❑	❑
Hepatitis, Jaundice, or Liver Trouble	❑	❑
Herpes	❑	❑
HIV-Positive/AIDS	❑	❑
Glaucoma	❑	❑
Do You Wear Contact Lenses?	❑	❑
Do you prefer nitrous oxide (laughing gas) during treatment	❑	❑
During the past 12 months have you taken any of the following?		
Antibiotics or sulfa drugs	❑	❑
Anticoagulants (e.g., Coumadin)	❑	❑
High blood pressure medicine	❑	❑
Tranquilizers	❑	❑
Insulin, Orinase, or similar drug	❑	❑
Aspirin	❑	❑
Digitalis or drugs for heart trouble	❑	❑
Nitroglycerin	❑	❑
Cortisone (steroids)	❑	❑
Over the counter medicine, herbs or vitamins	❑	❑

or other not listed above______________________________

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Women		
Are you taking contraceptives or other hormones?	❑	❑
Are you pregnant?	❑	❑

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