



# PATIENT MEDICAL & DENTAL HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

## Patient Medical History

Physician: \_\_\_\_\_ Office Telephone: \_\_\_\_\_

Approximate date of last physical examination: \_\_\_\_\_

	Yes	No
1. Are you under any medical treatment now?	_____	_____
2. Have you ever had a serious accident involving head injuries?	_____	_____
3. Have you ever had an adverse response to any drugs including penicillin?	_____	_____
4. Has a physician ever informed you that you had:		
A heart ailment?	_____	_____
Diabetes?	_____	_____
Rheumatic fever?	_____	_____
Rheumatism or arthritis?	_____	_____
Any blood disease?	_____	_____
Yellow Jaundice or Hepatitis?	_____	_____
Epilepsy (seizures)?	_____	_____
HIV (AIDS)?	_____	_____
5. Are you now taking drugs or medications?	_____	_____
6. Are you allergic to any known materials resulting in hives, asthma, eczema?	_____	_____
7. Have any wounds healed slowly or presented other complications?	_____	_____
8. Are you in good health at this time?	_____	_____

## Patient Dental History

1. Do you have pain in or near your ears?	_____	_____
2. Do you hear "clicks" or "pops" when opening your mouth?	_____	_____
3. Do you find yourself clenching your teeth together often?	_____	_____
4. Are your jaw muscles frequently sore in the morning?	_____	_____
5. Does it hurt to open your mouth wide?	_____	_____
6. Do your gums bleed easily when you brush your teeth?	_____	_____
7. Do you at present have any dental complaints?	_____	_____
8. When was your last full mouth X-ray taken?	_____	_____
9. When was your last dental check-up?	_____	_____

Signed \_\_\_\_\_