

Name: _____

Date: _____

PATIENT MEDICAL HISTORY

Do you currently have or have you ever had any of the following?

Blood Problems (Anemia)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart problems or Heart surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes or Cold Sores	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Murmur, Mitral Valve Prolapse, or Heart Defect	Yes <input type="checkbox"/> No <input type="checkbox"/>	AIDS or HIV Positive	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis A, B, or C	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer/Tumor	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bone or Joint Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heavy Bleeding After Any Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Joints or Heart Valve	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hay Fever or Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Immune Compromised	Yes <input type="checkbox"/> No <input type="checkbox"/>
High or Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy or Radiation Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Donor Organs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis or Other Lung Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are You Pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do You Smoke, Vape, or Use Tobacco?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Taking Hormones or Contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does your medical doctor want you to take antibiotics prior to dental visits?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Are you allergic to, or have you reacted adversely to any of the following?

Latex	Yes <input type="checkbox"/> No <input type="checkbox"/>	Local Anesthetics	Yes <input type="checkbox"/> No <input type="checkbox"/>
Penicillin or Other Antibiotics	Yes <input type="checkbox"/> No <input type="checkbox"/>	Codeine or Other Narcotics	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other: _____			

List any current medications that you are taking or should be taking:

PATIENT DENTAL HISTORY

Do you have any specific problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ever had a growth or sore spots in mouth?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain in or near your ears?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any part or mouth hurt when clenched?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you clench or grind your teeth?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ever had novocaine anesthetic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any difficult extractions in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any prolonged bleeding after extractions?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any part of your mouth sore to pressure, hot cold, sweet?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ever been instructed on correct method of brushing and flossing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you chew on only one side of your mouth due to discomfort?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swelling or unhealed mouth injuries?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do your gums bleed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other: _____	

I certify that the information given above is true to the best of my knowledge.

Name (print): _____ Date: _____

Signature: _____