OFFICE USE ONLY	
Prophy	
BWX	
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Panorex	

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FMX or BWX	
Dr.	

PATIENT MEDICAL/DENTAL HISTORY FORM

Patient's Name _____ Age _____ Date _____

Date of Birth _____ Single _____ Married _____ Separated _____ Widowed _____

Name of Spouse _____ Date of Birth _____

If a Child, Parent's Name _____

Residence - Street _____ Drivers License No. _____ State _____

City _____ State _____ Zip _____

Patient's Social Security Number _____ Spouse's Social Security Number _____

Telephone: Residence _____ Cell _____ Business _____

Patient employed by _____ Present Position _____ How long held _____

Spouse employed by _____ Present Position _____ How long held _____

Referred by _____ Who will pay this Account _____

Name of Dental Insurance Company and Policy Number _____

The following information is to be reviewed by the doctor and will be held in strictest confidence. It is important that you complete this medical history form in its entirety so that we may accurately diagnose and treat you, according to your general health and wellbeing. If you have any questions or require assistance in completing this medical history form, please ask our staff to help. Thank you for allowing us to serve your dental health care needs.

Reason for this visit: _____

GENERAL MEDICAL HISTORY

In the following questions circle yes or no

Are you presently in good health?	Yes	No
Are you presently under the care of a physician?	Yes	No
If yes, what is the nature of your illness?		
Name of your physician:		
Have you been hospitalized or had a major illness, operation or injury in the last 5 years?	Yes	No
If yes, please explain:		
Are you on a blood thinner?	Yes	No
Are you taking or have taken medication for **OSTEOPOROSIS** (bone loss)?	Yes	No
Please list all medications you are currently taking, including over-the-counter drugs:		
Allergies to anesthetics?	Yes	No
Allergies to medicine or drugs?	Yes	No
If yes, name them:		
For women, only: Is there a possibility that you may be pregnant?	Yes	No
If yes, give due date: _____		
Are you nursing?	Yes	No
Have you ever been treated for cancer? If yes, please explain type of treatment.	Yes	No

Do you have prosthetic (man-made) joints or heart valves?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have or have you been exposed to any of the following diseases?		
• AIDS	Yes	No
• Herpes	Yes	No
• Mononucleosis	Yes	No
• Respiratory illness	Yes	No
• Hepatitis (any form)	Yes	No
Have you lost 10 or more pounds in the last 6 months without dieting?	Yes	No
Did you ever have a blood transfusion, particularly prior to March 1985?	Yes	No
Do you have any sores in your mouth or on other parts of your body?	Yes	No
Have you had sores in or around your mouth or on other parts of your body in the past which occasionally return?	Yes	No
Do you drink alcohol? If yes, how often?	Yes	No
Do you use tobacco products? If so, how much? What form?	Yes	No
Are you currently using unprescribed "street drugs"?	Yes	No
Do you tire easily?	Yes	No
Do you have night sweats?	Yes	No
Do you have persistent fever?	Yes	No

(Over)

Have you ever had or been treated for any of the following conditions or diseases?

AIDS/ARC/HIV+	Yes	No
Anemia	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Circulatory problems	Yes	No
Diabetes	Yes	No
Diverticulitis/Colitis	Yes	No
Dizziness	Yes	No
Excessive bleeding	Yes	No
Glaucoma	Yes	No
Heart problems of any kind Please explain:	Yes	No
High blood pressure	Yes	No
Kidney/bladder infection	Yes	No
Low blood pressure	Yes	No
Malignancies (cancers)	Yes	No
Measles	Yes	No
Mumps	Yes	No
Nervous disorders	Yes	No
Painful urination	Yes	No
Rheumatic fever	Yes	No
Scarlet fever	Yes	No
Shortness of breath	Yes	No
Sinus problems	Yes	No
Stroke	Yes	No
Thyphoid fever	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Ulcers	Yes	No
Other If yes, please specify:	Yes	No

Please describe any current medical treatments, surgeries or any other medical or dental information that may affect your dental treatment.

DENTAL HISTORY

Have you ever experienced a problem with local anesthesia?	Yes	No
Do you have pain/clicking when opening or closing your jaw?	Yes	No
Have you ever had TMJ treatment?	Yes	No
Do you have any discomfort in your mouth presently?	Yes	No
Are your teeth sensitive to heat? Cold? Sweets?	Yes	No

If yes, please indicate which:

Have you ever had your teeth straightened?	Yes	No
Have you ever been diagnosed as having periodontal disease?	Yes	No
Do you grind or clench your teeth?	Yes	No
Are you aware of any swelling or lump in your mouth?	Yes	No
Do your gums bleed when you brush your teeth?	Yes	No
Do you get frequent blisters on the lips or mouth?	Yes	No
Are you aware of any oral habits (thumb sucking, nail biting, mouth breathing, etc.)?	Yes	No

If yes, please indicate:

How often do you brush your teeth per day? _____
or per week? _____

How often do you use dental floss per day? _____
or per week? _____

The information given about my health history in this form is accurate to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests (including X-rays), an evaluation of my dental health, and a credit history.

Signature of patient, parent or guardian Date

Medical review: I have reviewed this medical history with patient, parent or guardian whose signature is above.

Signature of Dentist Date

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DATE	SERVICE RENDERED	CHARGE	CREDIT	BALANCE