Patient Medical/Dental Information

A.Y. Family DENTAL

Welcome to our practice!

Date_____

Name_____ _____
First Mi Last Preferred Name

Birthdate_____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you taking any medication(s) including non-prescription medicine? Yes No
   If yes, what medication(s) are you taking? _____
   _____
4. Do you use tobacco? Yes No
5. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (i.e. Novocaine) Yes No		Aspirin	Yes No
Penicillin or other antibiotics	Yes No	Latex	Yes No
Other: Yes or No If yes, _____		Sulfa Drugs	Yes No

6. Do you have a persistent cough or throat clearing not associated with a known illness (Lasting more than 3 weeks?) Yes No
7. Women only:
   A) Are you pregnant or think you may be pregnant? Yes No
   B) Are you nursing? Yes No
   C) Are you taking Birth Control Pills? Yes No
8. Do you have or have you had any of the following?

High Blood Pressure	Yes	No	Heart Disease	Yes	No	Chest Pains	Yes	No
Heart Attack	Yes	No	Cardiac Pacemaker	Yes	No	Sleep Apnea	Yes	No
Rheumatic Fever	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Hay Fever/Allergies	Yes	No	Angina	Yes	No	Fainting/Seizures	Yes	No
Tuberculosis	Yes	No	Asthma	Yes	No	Radiation Therapy	Yes	No
Anemia	Yes	No	Epilepsy/Convulsions	Yes	No	Cancer	Yes	No
Arthritis	Yes	No	Liver Disease	Yes	No	Diabetes	Yes	No
Joint Replacement	Yes	No	Heart Trouble	Yes	No	Kidney Diseases	Yes	No
Hepatitis/Jaundice	Yes	No	Respiratory Problems	Yes	No	AIDS or HIV Infection	Yes	No
Stomach Troubles	Yes	No	Mitral Valve Prolapse	Yes	No	Artificial Heart Valves	Yes	No
Osteoporosis	Yes	No	Other_____					

Patient Dental History

1. Do your gums bleed while brushing or flossing? Yes No

2. Are your teeth sensitive to hot or cold liquids/foods? Yes No

3. Are your teeth sensitive to sweet or sour liquids/foods? Yes No

4. Do you feel pain to any of your teeth? Yes No

5. Do you have any sores or lumps in or near your mouth? Yes No

6. Have you had any head, neck or Jaw Injuries? Yes No

7. Have you experienced any of the following problems in your jaw?
A) Clicking-Yes No B) Pain (Joint, Ear, Side of Face)?-Yes No C) Difficulty in Opening or Closing?-Yes No
D) Difficulty in Chewing?-Yes No

8. Do you have frequent headaches? Yes No

9. Do you clench or grind your teeth? Yes No

10. Do you bite your lips or cheeks frequently? Yes No

11. Have you had any orthodontic work? Yes No

12. Have you ever had any difficult extractions in the past? Yes No

13. Do you snore? Yes No

14. Have you ever had prolonged bleeding following extractions? Yes No

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____ _____
Signature of patient or parent/guardian if minor Date