Patient History

Patient : last name : ______________________ first name : ______________________ mid name : ____________________

Do you have reular medical checkups? ☐ Yes ☐ No

Are you under the care of a physician now? ☐ Yes ☐ No Reason : ______________________

Are you been hospitalized recently? ☐ Yes ☐ No Reason : ______________________

Have you ever had a serious head injury? ☐ Yes ☐ No Explain : ______________________

Are you taking any medications? ☐ Yes ☐ No Explain : ______________________

Have you taken either oral or IV bisphosphonates? ☐ Yes ☐ No Explain : ______________________

Are you allergic to any medications? ☐ Yes ☐ No Explain : ______________________

Are you allergic to any other substances? ☐ Yes ☐ No Explain : ______________________

Do you smoke or use smokeless tobacco? ☐ Yes ☐ No Explain : ______________________

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

Heart Disease/ Disorder -

☐ Heart Attack/ Failure ☐ Angina/ Chest Pain ☐ Irregular Heart Beat ☐ Heart Murmur/ Rh Fever

☐ Mitral Valve Prolapse ☐ Bacterial Endocarditis ☐ Artificial Heart Valve ☐ Pacemaker/ Defibrillator

☐ Heart Surgery/ Stent

Lung Disease/ Disorder -

☐ Tuberculosis ☐ Asthma/ Emphysema ☐ Persistent Cough ☐ Sinus Problem/ Allergy

Reheumatism/ Arthrtis -

☐ Osteoporosis ☐ Artificial Joint ☐ Cortisone Treatment

Kidney Disease/ Disorder -

☐ Rehal Failure/ Dialysis

Cold Sores/ Fever Blisters -

☐ Hives or Rash ☐ HIV Positive/ AIDS ☐ Venereal Disease/ Genital Herpes

Liver Disease/ Disorder -

☐ Hepatitis A, B, C, Other ☐ Diabetes or Family History ☐ Excessive Thirst/ Urination

Neurological Disease/ Disorder -

☐ Epilepsy/ Seizures ☐ Fainting/ Dizziness

Digestive Disorder/ Reflux -

☐ Ulcers/ Diarrhea ☐ Recent Weight Loss/ Gain ☐ Colon Disease/ Disorder ☐ Thyroid/ Parathyroid Disease

Cancer / Tumors -

☐ Chemotherapy/ Radiation ☐ Psychiatric Care ☐ Drug Addition/ Alcoholism ☐ Alzheimers/ Demetia

Do you have any health issures not listed above?

Women - Are you pregnant, think you may be pregnant or currently nursing? ☐ Yes ☐ No

Have you ever been told you needed to take antibiotics before a dental proceduer? ☐ Yes ☐ No
If yes, Why?

☐ To the best of my knowledge, all proceding answers are correct. If I have any changes in my health status or medications, I shall inform the dentist and/or staff at the next appointmnet.

THESE QUESTIONS WILL HELP YOU IDENTIFY AND COMMUNICATE TO US IMPORTANT PERSONAL ISSUES WITH RESPECT TO YOUR DENTAL GOALS.

1. Why are you coming to see us?

2. What is important to you about your teeth?

3. How would you describe the present condition of your mouth?

4. How do you feel about the appearance of your smile?

5. How do you see your teeth 20 years from now?

6. What has kept you from going ahead with the dentistry you want?

7. What quality of dentistry are you looking for?

8. Describe your idea dental office/ provider.

9. What else would you like us to know about you?

Signature: ______________________ Date: ____________