PATIENT’S NAME D DATE OF BIRTH DSS# d

**PATIENT INFORMATION**

ADDRESS CITY STATE D ZIPCODE D

DRIVER’S

LICENSE #

CELL # HOME # WORK # D

PERSON TO CONTACT IN CASE OF EMERGENCY D PHONE D

WHOM MAY WE THANK FOR REFERRING YOU? D

**If patient is under 18yrs of age:**

PERSON RESPONSIBLE FOR THIS ACCOUNT RELATIONSHIP TO PATIENT D

**PATIENT MEDICAL HISTORY**

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

**YES NO**

1. ARE YOU IN GOOD HEALTH…………………………..
2. HAVE THERE BEEN ANY CHANGES IN

YOUR GENERAL HEALTH……………………............

1. PHYSICIAN’S NAME D
2. HAVE YOU EVER HAD ANY MAJOR SURGICAL

OPERATION OR JOINT REPLACEMENT…………..

PLEASE LIST & WHEN D

1. DO YOU BRUISE EASILY…………………………………
2. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION……………………………………………….
3. DO YOU HAVE A COUGH OR THROAT CLEARING

NOT ASSOCIATED WITH A KNOWN ILLNESS

(LASTING MORE THAN 3 WEEKS)……………**…….**

1. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES…………………………………………………

**CHECK ONLY** IF YOU HAVE A HISTORY OF, OR CONDITIONS RELATED TO ANY OF THE FOLLOWING:

**YES NO**

1. DO YOU USE TOBACCO……………………………….…
2. DO YOU HAVE ANY DISEASE, CONDITION,

OR PROBLEM NOT LISTED THAT YOU THINK

I SHOULD KNOW ABOUT D

1. PLEASE LIST ANY MEDICATIONS & NON-

PRESCRIPTION MEDICINE YOU ARE TAKING D d

D

**WOMEN ONLY**

ARE YOU PREGNANT OR THINK YOU MAY

BE PREGNANT………………………………………………..

ARE YOU NURSING………………………………...........

ARE YOU TAKING BIRTH CONTROL PILLS………..

HEART TROUBLE/ATTACK, OR ANGINA…. LUNG/BREATHING PROBLEMS… CHEMOTHERAPY(cancer/tumors)….

HEART SURGERY…………………………………… ASTHMA…………………………………….. CHEMICAL DEPENDENCY……………….

PACEMAKER…………………………………………. SINUS TROUBLE…………………………. ANEMIA(IRON DEFICIENCY)…………...

STROKE…………………………………………………. KIDNEYS…………………………………….. COLD SORES/FEVER BLISTERS………..

HIGH/LOW BLOOD PRESSURE……………….. DIABETES…………………………………… TONSILLITIS……………………………………

BLOOD………………………………….................. HEARTBURN/ACID REFLUX………… MENTAL HEALTH CARE………………….

THYROID……………………………….................. EPILEPSY/SEIZURES……………………. EATING DISORDER…………………………

LIVER/HEPATITIS/JAUNDICE………............ TUBERCULOSIS………………………….. SNORING……………………………………….

AIDS OR HIV INFECTION……………............. ABNORMAL BLEEDING………………. SLEEP APNEA…………………………………

SEXUALLY TRANSMITTED DISEASE……….. ARTHRITIS/RHEUMATISM…………. CORTISONE TREATMENT……………….

**CHECK ONLY** IF YOU ARE ALLERGIC TO OR HAVE HAD REACTIONS/PROBLEMS WITH THE FOLLOWING:

LOCAL ANESTHETICS (NOVOCAINE)…….. ASPIRIN………………………………….. OTHER (PLEASE LIST):

PENICILLIN OR OTHER ANTIBIOTICS…….. IODINE…………………………………….

SULFA DRUGS……………………………………… METALS(nickel,mercury,etc.)….

BARBITURATES……………………................. LATEX/RUBBER……………………….

SEDATIVES OR SLEEPING PILLS……………. SEASONAL……………………………….

**REGISTRATION / HEALTH HISTORY OVER**