

Patient Information

Patient Name: _____ Date: _____

Gender: Male Female Last, First MI (Preferred Name) Status: Minor Single Married Divorced Separated

Occupation: _____ Company: _____

Date of Birth: _____ E-mail address: _____

Address: _____ Phone (Home): _____

Street Apartment # _____ (Work): _____ (Cell): _____
City State Zip Code

Name of Spouse: _____ Closest Relative: _____ (Phone): _____

Whom may we thank for referring you to our practice? _____

Chief Complaint

The reason I'm here today is: _____

What area are you having problems? _____

How long has this been bothering you? _____

Are you presently experiencing pain? _____ To hot? _____ To cold? _____ To biting? _____ To sweets? _____

Dental History

Frequency of visits to dentist: _____ Type of care received: _____

Date of last dental visit? _____ Date of most recent x-rays: _____

Previous dentist information (name, address, phone): _____

Is there anything you especially liked or disliked about your previous dental office? _____

Difficulties with past treatment: _____

Adverse reactions to local anesthetics, latex gloves, rubber dam: _____

Have your parents or brothers/sisters experienced tooth loss? _____

Medical and Social History

Are you now or have you been under the care of a physician during the past 12 months? _____

Last time at physician: _____ For what purpose? _____

Physician: _____ Physician's phone #: _____

Do you have any known allergies or sensitivities? _____

Do you take any medications or pills at the present time? _____

Do you have a heart or joint condition that needs premedication? If yes, please list names and doses below: _____

Are you taking aspirin daily or on blood thinners? _____

Smoking: _____ Alcohol: _____ Recreational Drug Use: _____

Females only: Do you take oral contraceptives? _____ Are you pregnant? _____

Have you noted a change in your menstrual pattern? _____

Have any members of your family ever been treated for the conditions listed or any other medical problems?

Diabetes: _____ High blood pressure: _____ Heart problems: _____ Seizures: _____

Other: _____

Review of Systems

Have you ever had or do you now have any of the conditions listed?

Skin

Itching _____
Rash _____
Ulcerations, lesions _____
Pigmentations _____
Lack or loss of body hair _____

Extremities

Varicose veins _____
Swollen, painful joints _____
Muscle weakness, pain _____
Bone deformity, fracture _____
Prosthetic joints _____

Eyes

Blurry vision _____
Double vision _____
Drooping of eyelid _____
Glaucoma _____

Ear, Nose, Throat

Earache _____
Hearing loss _____
Frequent nosebleeds _____
Sinusitis _____
Frequent sore throat _____
Hoarseness _____
Ringing of ears, tinnitus _____

Respiratory

Cough, blood in sputum _____
Emphysema, bronchitis _____
Wheezing, asthma _____
Tuberculosis, exposure to _____

Cardiac

Shortness of breath _____
Pain, pressure in chest _____
Swelling of ankles _____
High blood pressure _____
Low blood pressure _____
Rheumatic, scarlet fever _____
Heart murmur _____
Heart attack _____
Prosthetic, artificial heart valves _____
Pacemaker _____

Gastrointestinal

Difficulty swallowing _____
Abdominal pain _____
Ulcers _____
Hepatitis _____
Jaundice _____
Liver disease _____

Genitourinary

Difficulty, pain on urination _____
Blood in urine _____
Excessive urination _____
Kidney infections _____
Sexually transmitted diseases _____

Endocrine

Thyroid trouble _____
Weight changes _____
Diabetes _____
Excessive thirst _____

Hematopoietic

Easy bruising, excessive bleeding _____
Persistent lymph node swellings _____
G6PD deficiency _____
Anemia _____
HIV infection, AIDS _____
Leukemia, problems with immune system _____
Spleen problems _____

Neurological

Frequent headaches, Migraines _____
Dizziness, fainting spells _____
Epilepsy, seizures _____
Neuritis, neuralgia _____
Paresthesias, numbness _____
Paralysis _____

Psychiatric

Nervousness, anxiety _____
Irritability _____
Depression _____
Nervous breakdown _____

Growths or Tumors

Radiation therapy _____
Chemotherapy _____

I certify that any and all questions I had about the inquiries above have been answered to my satisfaction. I was asked all of the questions on this form and I have answered these questions truthfully and completely. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made.

Signature of patient or guardian: _____ Date: _____

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Medical History Update:

Date: _____ Comments: _____ Signature: _____

