Patient Medical History Form

PATIENT INFORMATION

Patient Number: _____ Age: _____ DOB: _____ Sex: _____
Patient Name: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____

Father / Husband: _____ Employer: _____Work #:_____
Mother / Wife: _____ Employer: _____Work #:_____
E-Mail: _____

Name of Dentist: **Date of last dental examination/visit:**
Referred by:

MEDICAL HISTORY

Y N	Heart Trouble	Y N	Diabetes	Y N	Allergic to Latex
Y N	Congenital Heart Defect/HeartMurmur	Y N	Cancer	Y N	Allergic to Plastic/Acrylics
Y N	Heart Surgery/Pacemaker	Y N	Arthritis	Y N	Allergic to Metals/Nickel
Y N	Abnormal Bleeding/Hemophilia	Y N	Tonsilitis	Y N	Allergic to Dental Anesthetics
Y N	Artificial Bone/Joint/Valve	Y N	Asthma	Y N	Allergic to Other:_____
Y N	Bone Disorders/Osteoporosis	Y N	Contact Lens		(besides medications)
Y N	Taking/ever taken Bisphosphonates	Y N	HIV+/AIDS	Y N	Women: Are you pregnant
Y N	Numerous Broken Bones	Y N	Any Surgeries		
Y N	Kidney/Liver/Spleen problems/missing		(list below)		
Y N	Convulsions/Epilepsy				
Y N	Rheumatic/Scarlet Fever				
Y N	Radiation Treatment/Chemotherapy				

Drugs or medications now taking _____
Allergies to any drugs or medications_____
Any other medical problems, conditions or surgeries_____

Have you ever had:

Y N Tonsils or Adenoids been removed? If yes, when?_____
Y N Do you snore at night?
Y N Do you grind your teeth at night?
Y N Any traumatic dental treatments?
Y N Had a previous orthodontic examination?
Y N Gums bleed when brushed?
Y N Did you ever suck your fingers, lip or other objects? If stopped, at what age _____
Y N Have you ever received a severe blow to the head or jaw?
How often do you brush your teeth? _____

List your hobbies and special interests: _____
Favorite Movie: _____Music:_____TV Show:_____
Patient's Occupation / School Level: _____
School: _____ Favorite Class: _____
What do you like most about your career or classes in School: _____
When you have free time, what do you like to do? _____

Sign_____ Date_____