Patient Medical History

Patient's Name: _____ Birthdate: _____

Health Problems that you may have, medication that you may be taking, could have an important interaction with the dentistry that you will be receiving. Thank you for answering these questions.

Are you in good health? Yes ___ No___ Are you under a doctor's care? Yes ___ No ___

Have you been hospitalized for any reason? (list) _____

Are you taking any medications? (list) _____

Are you taking any anticoagulants? Yes___ No___ Have you taken any bisphosphonantes? Yes___ No___

Women Only: Pregnant Yes ___ No ___ Nursing Yes ___ No ___ Taking Birth Control Yes ___ No ___

Are you allergic to or have you had a reaction to any of the following?

Local Anesthetic Yes ___ No ___
Codeine Yes ___ No ___
Metal Yes ___ No ___
Penicillin Yes ___ No___
Latex Yes ___ No ___
Other _____
Aspirin Yes ___ No ___
Sulfa Drugs Yes ___ No___

Do you have or have you had any of the following:

AIDS/HIV Positive Yes ___ No ___
Anemia Yes ___ No ___
Artificial Heart Valve Yes ___ No ___
Blood Disease Yes ___ No ___
Breathing Problems Yes ___ No ___
Chest Pains Yes ___ No ___
Congenital Heart Disorder Yes ___ No ___
Drug Addiction Yes ___ No ___
Epilepsy/Seizures Yes ___ No ___
Faint/Dizzy Spells Yes ___ No ___
Frequent Headaches Yes ___ No ___
Hay Fever Yes ___ No ___
Hemophilia Yes ___ No ___
Herpes Yes ___ No ___
Hives or Rash Yes ___ No ___
Kidney Problems Yes ___ No ___
Low Blood Pressure Yes ___ No ___
Mitral Valve Prolapse Yes ___ No ___
Radiation Treatment Yes ___ No ___
Rheumatic Fever Yes ___ No ___
Shingles Yes ___ No ___
Spinal Bifida Yes ___ No ___
Swelling of Limbs Yes ___ No ___
Tuberculosis Yes ___ No ___
Venereal Disease Yes ___ No ___

Alzheimer Disease Yes ___ No___
Angina Yes ___ No ___
Artificial Joint Yes ___ No ___
Blood Transfusion Yes ___ No ___
Cancer Yes ___ No ___
Cold Sores/Fever Blister Yes ___ No ___
Cortisone Medicine Yes ___ No ___
Easily Winded Yes ___ No ___
Excessive Bleeding Yes ___ No ___
Frequent Cough Yes ___ No ___
Genital Herpes Yes ___ No ___
Heart Attack/Failure Yes ___ No ___
Hepatitis A Yes ___ No ___
High Blood Pressure Yes ___ No ___
Hypoglycemia Yes ___ No ___
Leukemia Yes ___ No ___
Lung Disease Yes ___ No ___
Parathyroid Disease Yes ___ No ___
Recent Weight Loss Yes ___ No ___
Rheumatism Yes ___ No ___
Sickle Cell Disease Yes ___ No ___
Stomach Disease Yes ___ No ___
Thyroid Disease Yes ___ No ___
Tumors or Growths Yes ___ No ___
Yellow Jaundice Yes ___ No ___

Anaphylaxis Yes ___ No ___
Arthritis/Gout Yes ___ No ___
Asthma Yes ___ No ___
Bruise Easily Yes ___ No ___
Chemotherapy Yes ___ No ___
Convulsions Yes ___ No ___
Diabetes Yes ___ No ___
Emphysema Yes ___ No ___
Excessive Thirst Yes ___ No ___
Frequent Diarrhea Yes ___ No ___
Glaucoma Yes ___ No ___
Heart Disease Yes ___ No ___
Hepatitis B or C Yes ___ No ___
High Cholesterol Yes ___ No ___
Irregular Heartbeat Yes ___ No ___
Liver Disease Yes ___ No ___
Osteoporosis Yes ___ No ___
Psychiatric Care Yes ___ No ___
Renal Dialysis Yes ___ No ___
Scarlet Fever Yes ___ No ___
Sinus Trouble Yes ___ No ___
Stoke Yes ___ No ___
Tonsillitis Yes ___ No ___
Ulcers Yes ___ No ___
Other _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to update the office of changes.

Signature of Patient or Guardian _____ Date _____

Dental History

Why have you come to the dentist today? _____

Do you have any special concerns regarding your visit? _____

Are you aware of any problems? _____

When was your last dental visit? _____ What was done? _____

Previous Dentist name: _____ Phone Number: _____

When was your last cleaning? _____ X-rays? _____

Have you ever been diagnosed with Periodontal Disease (Gum Disease)? _____

Do you have or had any of the following:

Abscess in mouth Yes ___ No ___
Any Food Traps Yes ___ No ___
Dry Mouth Yes ___ No ___
Gags Easily Yes ___ No ___
Bad Breath Yes ___ No ___
Snore Yes ___ No ___

Difficulty Chewing Yes ___ No ___
Bleeding Gums Yes ___ No ___
Sensitive Gums Yes ___ No ___
Pain in Ears/Face Yes ___ No ___
Pain in Jaw Joint Yes ___ No ___
Blisters Lip ___ Mouth ___

Loose Teeth Yes ___ No ___
Cold Sores Yes ___ No ___
Clench/Grind Yes ___ No ___
Infected Gums Yes ___ No ___
Missing Teeth Yes ___ No ___
Swelling (where) _____

Smoke (how much) _____ Dip/Chew (how much) _____ Drink (how much) _____

Sensitive to: Hot ____ Cold ____ Sweets ____

What type of toothbrush do you use? (circle) Soft Medium Hard Electric

Are you happy with the way your smile looks? Yes ___ No ___
If not, what would you change? (circle) Shape Whiter Straighter Close the Gaps
Shorter Teeth Longer Teeth Less Crowded Mouth Other _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand this information will be used by Dr. Clements and staff to help determine appropriate and healthful dental treatment. I will notify Dr. Clements with any changes in my medical status. I authorize my insurance company to pay to Dr. Clements all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions. I authorize Dr. Clements to release all information necessary to secure payment on my behalf. I understand I am fully responsible for all charges whether covered or not or denied by my insurance company within 60 days.

Patient (Or Guardian's) Signature _____ Date _____