Patient Medical & Dental History

Physician _____Office Phone _____Date of Last Exam_____

	Yes	No
1. Are you under any medical treatment now?	☐	☐
2. Have you ever been hospitalized for any Surgical Operations or serious illness within the last 5 years?	☐	☐
If yes please explain _____ _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes please explain_____ _____		
4. Have you ever taken Phen-fen or Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or had any reactions to Any of the following?	Yes	No
Local anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____	☐	☐
Women only:		
A.) Are you pregnant or think you may be?	☐	☐
B.) Are you nursing?	☐	☐
C.) Are you taking oral contraceptives?	☐	☐

----------Do you have or have you had any of the following?----------

	Yes	No		Yes	No		Yes	No
Allergies//Hay Fever	☐	☐	Do you drink grapefruit	☐	☐	Pacemaker	☐	☐
Anemia	☐	☐	Head Injuries	☐	☐	Penicillin Allergy	☐	☐
Angina	☐	☐	Heart Attack	☐	☐	Pregnancy/Nursing	☐	☐
Aspirin Allergy	☐	☐	Heart Disease	☐	☐	Pre-Med. before procedure	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Radiation Therapy	☐	☐
Barbiturate Allergy	☐	☐	Hepatitis A or C	☐	☐	Respiratory Problems	☐	☐
Benadryl Allergy	☐	☐	Hepatitis B	☐	☐	Rheumatic Fever History	☐	☐
Benign Tumor History	☐	☐	Hepatitis/Jaundice	☐	☐	Rheumatoid Arthritis	☐	☐
Blood Disease	☐	☐	High Blood Pressure	☐	☐	Sinus Problems	☐	☐
Cancer	☐	☐	HIV	☐	☐	Stomach Problems	☐	☐
Cardiac Pacemaker	☐	☐	Ibuprofen Sensitive	☐	☐	Stroke History	☐	☐
Codeine Allergy	☐	☐	Joint Replacement	☐	☐	Sulfa Drug Allergy	☐	☐
Diabetes Type I	☐	☐	Kidney Disease	☐	☐	Thyroid Problem	☐	☐
Diabetes Type II	☐	☐	Liver Disease	☐	☐	Tobacco user (chew)	☐	☐
Dizziness/Vertigo	☐	☐	Low Blood Pressure	☐	☐	Tobacco (smoke)	☐	☐
Emphysema	☐	☐	Mental Disorders	☐	☐	Tuberculosis	☐	☐
Epi Sensitive	☐	☐	Mitro Valve Prolapse	☐	☐	Ulcers	☐	☐
Epilepsy/Convulsions	☐	☐	Nervous Disorders	☐	☐	Venereal Diseases/STD	☐	☐
Fainting and seizures	☐	☐	Obese	☐	☐			
Fibromyalgia	☐	☐	Osteoarthritis	☐	☐			

Name of Previous Dentist and Location _____Date of Last Exam_____

1. Do your gums bleed while brushing or flossing? **Yes or No**
2. Are your teeth sensitive to hot or cold liquids/foods? **Yes or No**
3. Do you feel pain in any of your teeth today? **Yes or No**
4. Do you have any sores or lumps in or near your mouth? **Yes or No**
5. Do you have frequent headaches? **Yes or No**
6. Do you clench or grind your teeth? **Yes or No**
7. Do you bite your lips or cheek frequently? **Yes or No**
8. Have you ever had any difficult extractions in the past? **Yes or No**
9. Have you ever had any prolonged bleeding following an extractions? **Yes or No**
10. Have you had orthodontic treatment? **Yes or No**
11. Do you wear dentures or partials? **Yes or No**
12. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? **Yes or No**
13. Do you have clicking or piping in your jaw? **Yes or No**
14. Do you have difficulty opening or closing your jaw? **Yes or No**
15. Do you have difficulty chewing? **Yes or No**

Authorization and Release

I certify that I have read and understand the above information and above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and any records of treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. By signing the line below, I certify that I have read and understand all the above information and any and all questions have been adequately answered by the staff of Bartlett Family Dentistry.

X_____

Signature of Patient, Parent or Legal Guardian Today's Date