PATIENT MEDICAL & DENTAL HISTORY

Date: _____

Name: _____ Birthdate: _____

Last First Middle

Address: _____

Street City Province Zip

Patient Medical History

Physician: _____Office Telephone: _____

Approximate date of last physical examination: _____

	Yes	No	
1. Are you under any medical treatment now?	___	___	_____
2. Have you ever had a serious accident involving head injuries?	___	___	_____
3. Have you ever had an adverse response to any drugs including penicillin?	___	___	_____
4. Has a physician ever informed you that you had:			
A heart ailment?	___	___	_____
Diabetes?	___	___	_____
Rheumatic fever?	___	___	_____
Rheumatism or arthritis?	___	___	_____
Any blood disease?	___	___	_____
Yellow Jaundice or Hepatitis?	___	___	_____
Epilepsy (seizures)?	___	___	_____
HIV (AIDS)?	___	___	_____
5. Are you now taking drugs or medications?	___	___	_____
6. Are you allergic to any know materials resulting in hives, asthma, eczema?	___	___	_____
7. Have any wounds healed slowly or presented other complications?	___	___	_____
8. Is there any other medical history that we should be aware of?	___	___	_____

Patient Dental History

1. Do you have pain in or near your ears?	___	___	_____
2. Do you hear “clicks” or “pops” when opening your mouth?	___	___	_____
3. Do you find yourself clenching your teeth together often?	___	___	_____
4. Are your jaw muscles frequently sore in the morning?	___	___	_____
5. Does it hurt to open your mouth wide?	___	___	_____
6. Do your gums bleed easily when you brush your teeth?	___	___	_____
7. Do you at present have any dental complaints?	___	___	_____
8. When was your last full mouth X-ray taken?	___	___	_____
9. When was your last dental check-up?	___	___	_____

Signature(Parent’s signature if minor)_____