Patient Record Sheet – Medical & Dental History

PLEASE FILL OUT THIS FORM COMPLETELY.
IF SOMETHING DOES NOT APPLY, PLEASE MARK IT AS "N/A." THANK YOU!

Today's Date: ______________ How did you hear about us? ________________________________

Patient Name ____ SSN* _____________ DOB ____________

Address ____ City ________________ Zip ____________

Phone #s: Home ( ) ______________ Work ( ) ______________ Cell ( ) ______________

(please circle the best phone number/s for us to contact you for appt confirmations or other issues)

NCDL#* ____ *Required unless you pay in full in cash only.

E-mail ____ Employer ______________________________

Name of spouse or legal guardian ____________________________________ Phone ( ) ____________

Name of Emergency contact ______________________________________ Phone ( ) ____________

Relationship to patient: ______________________________________

Medical Dr. __________________________ Phone ( ) ______________ Last exam date ______________

1. Are you currently under medical treatment? Y / N
2. Have you ever been hospitalized for any surgical operation or serious illness? Y / N
3. Are you taking any medications, including non-prescription medicine? Y / N

   If yes to any of above, please list:

   ____

   ____

   ____
4. Have you ever taken Fen Phen or Redux? Y / N
5. Do you use tobacco? Y / N
6. Do you use alcohol or other drugs? Y / N
7. WOMEN ONLY: a) Are you pregnant or think you may be? Y / N b) Are you nursing? Y / N
   c) Are you taking birth control pills? Y / N

Check substances that cause you to have allergic or unfavorable reactions:

- ☐ Dental anesthetics
- ☐ Barbiturates
- ☐ Aspirin
- ☐ Penicillin
- ☐ Sedatives
- ☐ Sulfa Drugs
- ☐ Metals
- ☐ Latex
- ☐ Other: ______________________ ______________________

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

Joint replacement	Y/N	Stroke	Y/N	Diabetes	Y/N	Kidney diseases	Y/N
Heart disease	Y/N	Easily winded	Y/N	Epilepsy/Convulsions	Y/N	Hepatitis/Jaundice	Y/N
Heart attack	Y/N	Frequently tired	Y/N	Fainting/Seizures	Y/N	Liver disease	Y/N
Heart murmur	Y/N	Respiratory problems	Y/N	Stomach problems	Y/N	Thyroid problems	Y/N
Cardiac pacemaker	Y/N	Emphysema	Y/N	Ulcers	Y/N	Arthritis	Y/N
Mitral valve prolapse	Y/N	Asthma	Y/N	Cancer	Y/N	Anemia	Y/N
Angina	Y/N	Tuberculosis	Y/N	Leukemia	Y/N	Glaucoma	Y/N
Chest pains	Y/N	Hay fever/Allergies	Y/N	Radiation therapy	Y/N	Recent weight loss	Y/N
Rheumatic fever	Y/N	High blood pressure	Y/N	AIDS/HIV	Y/N		
Swollen ankles	Y/N	Low blood pressure	Y/N	Sexually transmitted diseases		Y/N	

Other: ________________________ ________________________ ________________________

Dental - Have you experienced any of the following?

Bleeding gums - brushing/flossing	Y/N	Head, neck, jaw injuries	Y/N	Clenching or grinding teeth	Y/N
Teeth sensitive to hot/cold liquids	Y/N	Clicking in jaw	Y/N	Frequent biting of lips/cheeks	Y/N
Teeth sensitive to sweet/sour foods	Y/N	Pain in jaw, ear, side of face	Y/N	Difficult extractions	Y/N
Teeth painful	Y/N	Difficulty chewing	Y/N	Instruction for brushing teeth	Y/N
Lumps or sores near or in mouth	Y/N	Frequent headaches	Y/N	Instruction for gum care	Y/N

All information I have provided is correct to the best of my knowledge.

______________________________________ ______________

Signature of Patient/Responsible Party Date