PATIENT MEDICAL HISTORY

Date _____

Name _____ Date of Birth _____ Sex _____

Address _____ City _____ Zip _____ Phone _____

Height _____ Weight _____ Occupation _____

Employer _____ Employer Address _____

Manager / Supervisor _____ Business Phone _____

Email _____ Social Security # _____ ☐ Married ☐ Single

Spouse _____ Nearest Relative _____

Person Responsible for Account _____

Physician _____ Office Phone _____

How did you hear about us? _____

Purpose of Call _____

	YES	NO
1. Are you under any medical treatment now?	☐	☐
2. Have you had any major operations? If so, what?	☐	☐
3. Have you ever had a serious accident involving head injuries?	☐	☐
4. Have you had any adverse response to any drugs including penicillin?	☐	☐
5. Has a physician ever informed you that you had: A Heart Ailment?	☐	☐
6. High Blood Pressure?	☐	☐
7. Respiratory Disease?	☐	☐
8. Diabetes?	☐	☐
9. Rheumatic Fever?	☐	☐
10. Rheumatism or Arthritis?	☐	☐
11. Tumors or Growths?	☐	☐
12. Any Blood Disease?	☐	☐
13. Any Liver Disease?	☐	☐
14. Any Kidney Disease?	☐	☐
15. Any Stomach or Intestinal Disease?	☐	☐
16. Any Venereal Disease?	☐	☐
17. Yellow Jaundice or Hepatitis?	☐	☐
18. Are you now taking drugs or medications?	☐	☐
19. Are you allergic to any known materials resulting – in hives, asthma, eczema, etc?	☐	☐
20. Have any wounds healed slowly or presented other complications?	☐	☐
21. Are you pregnant?	☐	☐
22. Do you have a history of fainting?	☐	☐
23. Have you ever had any X-RAY TREATMENTS (other than diagnostic)?	☐	☐
24. Do you have pain in or near your ears?	☐	☐
25. Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
26. Have you experienced any growth or sore spots in your mouth?	☐	☐
27. Does any part of your mouth hurt when clenched?	☐	☐
28. Have you ever had Novocaine anesthetic?	☐	☐
Any reactions or allergic symptoms to novocaine?	☐	☐
Any difficult extractions in the past?	☐	☐
Prolonged bleeding following extractions in the past?	☐	☐
Trench Mouth?	☐	☐
29. Do your gums bleed?	☐	☐
30. When was your last full mouth X-RAY taken? If so, where? _____	☐	☐
31. Any part of your mouth sore to pressures or irritants (cold, sweets, etc...)	☐	☐
32. If so locate	☐	☐
33. Do you have any symptoms related to AIDS	☐	☐

Signature _____