



# Patient Medical History

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

WHITEANDHAINES  
advanced dentistry

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

general dentistry  
Steven M. White DDS, PA  
Brod S. Haines DDS, PA

- |   |                          |                          |  |                          |                          |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
|   | Yes                      | No                       |  | Yes                      | No                       |
| 1. Are you under medical treatment now?   | <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you allergic to or have you had any reactions to the following? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. noocaine)                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?          | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____  |                          |                          | Sulfa Drugs  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Barbiturates   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use tobacco?  | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs?                                    | <input type="checkbox"/> | <input type="checkbox"/> | Iodine   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken Phen-Phen?   | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Women Only:  |                          |                          | Latex Sensitivity  | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Are you pregnant or think you may be pregnant?                                 | <input type="checkbox"/> | <input type="checkbox"/> | Please list any other allergies: _____                                 |                          |                          |
| b) Are you nursing?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| c) Are you taking birth control pills?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

Do you have any of the following?

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|------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|
|                        | Yes                      | No                       |                           | Yes                      | No                       |                      | Yes                      | No                       |
| High Blood Pressure    | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease             | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains          | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack           | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker         | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded        | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever        | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur              | <input type="checkbox"/> | <input type="checkbox"/> | Stroke               | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles         | <input type="checkbox"/> | <input type="checkbox"/> | Angina                    | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures      | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired          | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis         | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                 | <input type="checkbox"/> | <input type="checkbox"/> | Anemia                    | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy    | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure     | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema                 | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma             | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions   | <input type="checkbox"/> | <input type="checkbox"/> | Cancer                    | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss   | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia               | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                 | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease        | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes               | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement/Implant | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble        | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases        | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice        | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection  | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem           | <input type="checkbox"/> | <input type="checkbox"/> | STDs                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Trouble/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |                           |                          |                          |                      |                          |                          |

## Patient Dental History

- |   |                          |                          |   |                          |                          |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
|   | Yes                      | No                       |   | Yes                      | No                       |
| 1. Do your gums bleed while brushing or flossing?                       | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?               | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?             | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?                               | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth?                | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any orthodontic work?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?                         | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had any prolonged bleeding following extractions?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? |                          |                          | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Clicking?  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had any instructions on the care of your gums?                | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)?                                     | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| c) Difficulty in opening or closing?                                    | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| d) Difficulty in chewing?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The 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 the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

X \_\_\_\_\_

Signature of patient or parent/guardian if minor

Date