SUITE DENTAL MEDICAL HISTORY

Patient information

Patient name: Date of birth: Sex: Age:

Home address: City: State: Zip:

Billing Address (if different): City: State: Zip:

Home phone: Cell: E-mail:

Social security #: Employer/Occupation:

Emergency contact: Emergency contact phone #:

Primary dental insurance: Group #:

Secondary dental insurance: Group #:

Subscriber's name: Date of birth: Social security #:

Name of your medical doctor: Date of last visit to medical doctor:

Name of previous dentist: Date of last visit to dentist:

Preferred contact method (Hm phone, Wk phone, Cell phone, E-mail):

Preferred contact method for confirmations (Hm phone, Wk phone, Cell phone, E-mail):

Referred to us by:

Dental Health History

Circle yes or no

Had an unfavorable dental experience	Yes	No	Do your gums bleed easily	Yes	No
Had trouble getting numb	Yes	No	Are your teeth sensitive	Yes	No
Had/have braces, orthodontic treatment	Yes	No	Do you take fluoride supplements	Yes	No
Had any teeth removed	Yes	No	Do you clench or grind	Yes	No
Had complications from past dental treatment	Yes	No	Have any discomfort in your jaw	Yes	No
Had any reactions to local anesthetic	Yes	No	Are you a habitual gum chewer	Yes	No
Had your bite adjusted	Yes	No	Do you smoke	Yes	No

Medical Health History

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

Heart problems

Chest pain	Yes	No
Shortness of breath	Yes	No
Blood pressure problem	Yes	No
Heart murmur	Yes	No
Heart valve problem	Yes	No
Taking heart medication	Yes	No
Rheumatic fever	Yes	No
Pacemaker	Yes	No
Artificial heart valve	Yes	No

Blood problems

Easy bruising	Yes	No
Frequent nosebleeds	Yes	No
Abnormal bleeding	Yes	No
Blood disease (anemia)	Yes	No
Ever require a blood transfusion	Yes	No

Allergy problems

Hay fever	Yes	No
Sinus problems	Yes	No
Skin rashes	Yes	No
Taking allergy medication	Yes	No
Asthma	Yes	No

Intestinal problems

Ulcers	Yes	No
Weight gain or loss	Yes	No
Special diet	Yes	No
Constipation/diarrhea	Yes	No
Kidney or bladder problems	Yes	No

Bone or joint problems

Arthritis	Yes	No
Back or neck pain	Yes	No
Joint replacement	Yes	No

During the last 12 months, have you taken any of the following?

Antibiotics or sulfa drugs	Yes	No
Anticoagulants	Yes	No
High blood pressure medication	Yes	No
Tranquilizers	Yes	No
Insulin, orinase, or similar drugs	Yes	No
Aspirin	Yes	No
Digitalis or drugs for heart trouble	Yes	No
Nitroglycerin	Yes	No

Cortisone (steroids)	Yes	No
Fainting spells, seizures, epilepsy	Yes	No
Stroke(s)	Yes	No
Frequent or severe headaches	Yes	No
Thyroid problems	Yes	No
Persistent cough or swollen glands	Yes	No
Premedications required by physician	Yes	No
Cancer/tumor	Yes	No

Diabetes

Urinate more than 6 times a day	Yes	No
Thirsty or mouth dry mouth	Yes	No
Family history of diabetes	Yes	No
Tuberculosis or other respiratory disease	Yes	No
Do you drink alcohol	Yes	No
If so, how much?		
Do you smoke	Yes	No
Hepatitis, jaundice, or liver trouble	Yes	No
Herpes or other STI	Yes	No
HIV-positive/AIDS	Yes	No
Glaucoma	Yes	No
Do you wear contact lenses	Yes	No
History of head injury	Yes	No
Epilepsy or other neurological diseases	Yes	No
History of alcohol or drug abuse	Yes	No

Do you have a disease, condition, or problem that is not listed above? If so, please describe.

Are you allergic, or have you reacted adversely, to any of the following?

Local anesthetics (Novocain)	Yes	No
Penicillin or other antibiotics	Yes	No
Sulfa drugs	Yes	No
Barbiturates, sedatives, or sleeping pills	Yes	No
Aspirin, acetaminophen, or ibuprofen	Yes	No
Codeine, Demerol, or other narcotics	Yes	No
Reaction to metals	Yes	No
Latex or rubber	Yes	No

Women

Are you taking contraceptives or other hormones	Yes	No
Are you pregnant	Yes	No
If so, expected delivery date:		
Are you nursing	Yes	No
Have you reached menopause	Yes	No
If so, do you have any symptoms?		