EVERGREEN Dental Care

Date _____

PATIENT MEDICAL HISTORY FORM

MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last exam _____

Are you under medical treatment now? ☐ Yes ☐ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No

If yes, please explain: _____

Are you any medication(s), including non-prescription? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever taken Biphosphonates? ☐ Yes ☐ No

Have you ever taken any cancer medications? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you allergic to or have reactions to the following:

Local Anesthetics (e.g. Novocaine)	☐ Yes	☐ No
Penicillin or Antibiotics	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Sedatives	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Any Metals (e.g. nickel, mercury, etc.)	☐ Yes	☐ No
Latex Rubber	☐ Yes	☐ No
Other (please list)	☐ Yes	☐ No

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No

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

High Blood Pressure	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Thyroid Problem	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Cardiac Pacemaker	☐ Yes	☐ No	Stomach Trouble/Ulcer	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Chest Pains	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Angina	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Fainting/Seizures	☐ Yes	☐ No	Heart Stent	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Joint Replacement/Implant	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Hepatitis/Jaundice	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
AIDS or HIV Infection	☐ Yes	☐ No	STD	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No

DENTAL HISTORY

Other ☐ Yes ☐ No

Previous dentist & location _____ Date of last exam _____

Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
Are your teeth sensitive to hot or cold?	☐ Yes	☐ No
Are your teeth sensitive to sweet or sour?	☐ Yes	☐ No
Do you feel pain to any of your teeth?	☐ Yes	☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
Have you had any head, neck, or jaw injuries?	☐ Yes	☐ No
Have you ever experienced any of the following:		
Jaw clicking	☐ Yes	☐ No
Pain (jaw, joint, ear, side of face)	☐ Yes	☐ No
Difficulty opening or closing jaw	☐ Yes	☐ No
Difficulty chewing	☐ Yes	☐ No

Do you have frequent headaches?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No
Have you had difficult extractions in the past?	☐ Yes	☐ No
Have you had prolonged bleeding after extractions?	☐ Yes	☐ No
Have you had any orthodontic treatment?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
If yes, date of placement: _____	☐ Yes	☐ No
Have you ever received oral hygiene instructions	☐ Yes	☐ No
regarding the care of your teeth and/or gums?	☐ Yes	☐ No
Do you like your smile?	☐ Yes	☐ No

AUTHORIZATION & 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. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____ Date _____

Signature of patient (or parent/guardian if a minor)