Anita W. Elliott, D.D.S., P.C.

# Patient Dental and Medical History--

PATIENT NAME _____ Today's Date _____

□Female □Male □Married □Single □Minor

Street Address _____City _____ State _____ Zip _____

Home Tel _____ - _____ - _____ Cell _____ - _____ - _____ e-mail address _____

I.D/S.S.# _____ - _____ - _____ Birthdate _____ / _____ / _____

## MEDICAL HISTORY

Physician: _____ Off Tel: _____ Date of Last Exam _____

| | YES | NO |
|---|---|---|
| Are you under medical treatment now? | □ | □ |
| Have you ever been hospitalized for any surgical operation or serious illness? | □ | □ |
| Have you ever taken Fen-Phen/Redux? | □ | □ |
| Do you use tobacco? | □ | □ |
| Do you use alcohol, cocaine or other drugs? | □ | □ |
| Are you wearing contact lenses? | □ | □ |
| Are you taking any medication(s) including non-prescription medicine? | □ | □ |

If YES, what medications(s) are you taking?_____

_____

Are you allergic to or have you had any reaction to the following:

| YES | NO | |
|---|---|---|
| □ | □ | Local Anesthetics (eg. Novocaine) |
| □ | □ | Barbiturates |
| □ | □ | Aspirin |
| □ | □ | Penicillin or other Antibiotics |
| □ | □ | Sulfa Drugs |
| □ | □ | Iodine |
| □ | □ | Sedatives |
| □ | □ | Other _____ |
| □ | □ | Do you have a persistent cough not associated with a known illness? |

**Women Only**

Are you...

Pregnant?

Nursing?

Taking Birth Control Pills?

Blood Pressure _____/_____

**Do you have or have you had any of the following:**

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| □ | □ | High Blood Pressure | □ | □ | Heart Disease | □ | □ | Chest Pains |
| □ | □ | Heart Attack | □ | □ | Cardiac Pacemaker | □ | □ | Heart Trouble |
| □ | □ | Heart Murmur | □ | □ | Easily Winded | □ | □ | Low Blood Pressure |
| □ | □ | Swollen Ankles | □ | □ | Glaucoma | □ | □ | Stroke |
| □ | □ | Rheumatic Fever | □ | □ | Fainting/Seizures | □ | □ | Angina |
| □ | □ | Hay Fever/Allergies | □ | □ | Frequently Tired | □ | □ | Tuberculosis |
| □ | □ | Asthma | □ | □ | Anemia | □ | □ | Emphysema |
| □ | □ | Epilepsy/Convulsions | □ | □ | Recent Weight Loss | □ | □ | Respiratory Problems |
| □ | □ | Leukemia | □ | □ | Cancer | □ | □ | Liver Disease |
| □ | □ | Radiation Therapy | □ | □ | Diabetes | □ | □ | Kidney Disease |
| □ | □ | Hepatitis/Jaundice | □ | □ | Arthritis | □ | □ | Joint Replacement |
| □ | □ | Thyroid Problem | □ | □ | Stomach Troubles | □ | □ | Implants-Any |
| □ | □ | AIDS/HIV Infection | □ | □ | STD/HPV/Herpes | □ | □ | Other_____ |

**Comments / Discoveries**

_____

_____

_____

_____

_____

_____

Dentist Signature _____

## DENTAL HISTORY

**Primary Reason for this dental appointment: □ Examination □ Emergency □ Consultation**

Do you have a specific dental problem? Describe _____

Date of your last dental examination, oral cancer screen, and full mouth series of x-rays? _____

Do you want to keep your remaining teeth? _____

Do you brush and floss regularly?_____ Do you brux or grind your teeth during the day or at night? _____

Do your gums bleed? _____ Are your tooth brush bristles pink colored after you brush or floss? _____

Do you ever have clicking, popping, locking, difficulty chewing or discomfort in the jaw joints? TMJ? Describe _____

Do you have sensitivity to hot or cold? _____ Do you have sensitivity to sweet or sour liquids or food? _____

Have you have any orthodontic treatment at any time? _____ Do you bite your lips or cheeks frequently? _____

Have you had any difficult extractions or prolonged bleeding after dental work? _____

Do you like the look of your teeth? _____ Do you like the look of your smile? _____ Do you like the color of your teeth and smile? _____

**The information on this Dental and Medical History is correct to the best of my knowledge. The questions above have been accurately answered.**

**Responsible Party Signature** _____ **Date** _____

**□Adult Patient □Father (or Husband) □Mother (or Wife) □Guardian**