Patient Medical History

Wilson Dental
General and Cosmetic Dentistry

To help us meet all your dental health-care needs, please fill out this form completely in ink.

Patient's Full Name		Date	Birthdate	Age

Address	City	State	Zip	Phone	Cell Phone

Employment	Position	Dental Ins. ☐ Yes ☐ No	Bus. Phone

Spouse, - Parent or Guardian, If Child	Person Responsible for Account	Who Referred You To This Office?

Date And Purpose Of Last Medical Visit____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
3. Have you ever taken Phen-Fen/Redux?	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you wear contact lenses?	☐	☐
6. Do you, or have you taken corticosteroids?	☐	☐

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

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Weight Change	☐	☐	Diabetes	☐	☐	Liver Disease
☐	☐	Acid Reflux Disease	☐	☐	Eating Disorders	☐	☐	Migraines
☐	☐	Addiction	☐	☐	Easily Winded	☐	☐	Mitral Valve Prolapse
☐	☐	AIDS or HIV Infection	☐	☐	Emphysema	☐	☐	Pacemaker
☐	☐	Allergies/ Hay Fever	☐	☐	Epilepsy / Seizures	☐	☐	Psychiatric Treatment
☐	☐	Anemia	☐	☐	Fainting / Dizziness	☐	☐	Radiation Treatment
☐	☐	Angina Pectoris	☐	☐	Glaucoma	☐	☐	Respiratory Problems
☐	☐	Anxiety Attacks	☐	☐	Heart Attack	☐	☐	Rheumatic Fever
☐	☐	Arthritis	☐	☐	Heart Disease	☐	☐	Sexually Transmitted Disease
☐	☐	Artificial Joints (Hip, Knee)	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Valve Replacement	☐	☐	Swollen Ankles
☐	☐	Bleeding Disorders	☐	☐	Hepatitis Type______	☐	☐	Thyroid Disease
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Tuberculosis
☐	☐	Chemotherapy	☐	☐	Kidney Disease	☐	☐	Ulcers/ Stomach Trouble
☐	☐	Chronic Cough						

8. Do you have any disease or condition not listed:_______

____

____

____

10. Are you allergic to or ever had any reactions to the following?	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Antibiotics	☐	☐
Codeine	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
*Other (please list)*________________	☐	☐

____

____

WOMEN ONLY

	Yes	No
A) Are you pregnant or think you may be pregnant?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking oral contraceptives?	☐	☐

OVER

9. List all medications, including non-prescription medications:

____
____
____
____
____
____

Patient Dental History

Name or Previous Dentist and Location ____

Date of Last Dental Visit__/__/__ For what purpose?______________________________

	Yes	No
1. Do your gums bleed while flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids or foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids or foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any lumps or sores in your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint/ear/side of face)	☐	☐
Difficulty opening and closing	☐	☐
Difficulty chewing	☐	☐
8. Do you have frequent head / neck aches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐

	Yes	No
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement___/___/___		
15. Have you ever received oral hygiene instructions regarding care of you teeth and gums?	☐	☐
16. Are you happy with your smile?	☐	☐
17. Are you concerned about spots or stains on your teeth?	☐	☐
18. Is your mouth abnormally dry?	☐	☐
19. Have you ever been diagnosed with gum disease?	☐	☐
20. Did you have treatment for gum disease?	☐	☐
21. Does food catch between any of your teeth?	☐	☐
22. Are there areas that are difficult to floss?	☐	☐

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect information could be dangerous to my health.

X____ Date___/___/___

Signature of Patient (or parent if minor)

Date	**Comments**	**Initial**