JEFF TOLLETT DDS
Dentistry made personal

Patient Medical History

Patient's Name_____ Chart#_____ DOB_____
Last First Initial MM-DD-YY

Physician_____ Office Phone_____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operations or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including Non-prescription ?	☐	☐
If yes PLEASE LIST on THE MEDICATION FORM		
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5 Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have had any reactions to the following?	Yes	No
Local Anesthetics (eq. Novocaine)	☐	☐
Penicillin or any other antibiotic	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (nickel, mercury etc)	☐	☐
Other (please list) _____	☐	☐
10. Women Only		
a) Are you or could you be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have had any of the following?

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes Type ___	☐	☐
Kidney Disease	☐	☐
AIDS / HIV Infection	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema / COPD	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement/Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐

	Yes	No
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Other _____	☐	☐

Patient Dental History

Previous Dentist_____ Office Phone_____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Have you ever experienced these in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening/closing	☐	☐
Difficulty chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had difficulty with extractions?	☐	☐
12. Have you had prolonged bleeding? With extractions?	☐	☐
13. Have you had orthodontic treatment (braces)?	☐	☐
14 Do you wear dentures or partials?	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X *Patient (or guardian) Signature:*_____ *Date* _____

*Dentist Signature:*_____ *Date* _____

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