

## The Washington Dental Studio

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PATIENT NAME

PATIENT NAME _____	TODAY'S DATE _____
HOME ADDRESS _____	DATE OF BIRTH _____
E-MAIL _____	HOME PHONE _____
EMPLOYER _____	CELL PHONE _____
INSURANCE CO. _____	BUSINESS PHONE _____
	SS#/SIN _____

### PATIENT MEDICAL HISTORY

PHYSICIAN _____	OFFICE PHONE _____	DATE OF LAST EXAM _____
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1. Are you under medical treatment now?  YES  NO

2. Have you ever been hospitalized for any surgical operation or serious illness?  YES  NO

3. Are you taking any medication(s) including non-prescription medicine?  YES  NO  
If yes, what medication(s) are you taking? \_\_\_\_\_

4. Have you ever taken Fen-Phen/Redux?  YES  NO

5. Do you use tobacco?  YES  NO

6. Do you use alcohol, cocaine or other drugs?  YES  NO

7. Are you wearing contact lenses?  YES  NO

8. Are you allergic to or have you had any reactions to the following?

YES NO <input type="checkbox"/> <input type="checkbox"/> Local anesthetics (eg. novocaine) YES NO <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics YES NO <input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs	YES NO <input type="checkbox"/> <input type="checkbox"/> Barbiturates YES NO <input type="checkbox"/> <input type="checkbox"/> Sedatives YES NO <input type="checkbox"/> <input type="checkbox"/> Iodine	YES NO <input type="checkbox"/> <input type="checkbox"/> Aspirin YES NO <input type="checkbox"/> <input type="checkbox"/> Other YES NO <input type="checkbox"/> <input type="checkbox"/> _____
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9. WOMEN ONLY YES NO

a) Are you pregnant or think you may be pregnant?  YES  NO

b) Are you nursing?  YES  NO

c) Are you taking birth control pills?  YES  NO

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?  YES  NO

11. Do you have or have you had any of the following? YES NO <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Heart Attack <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> <input type="checkbox"/> Fainting / Seizures <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Low / High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Convulsions <input type="checkbox"/> <input type="checkbox"/> Leukemia <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Kidney Diseases <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Infection <input type="checkbox"/> <input type="checkbox"/> Thyroid Problem	YES NO <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker <input type="checkbox"/> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> <input type="checkbox"/> Angina <input type="checkbox"/> <input type="checkbox"/> Frequently Tired <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Emphysema <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Joint Replacement or Implant <input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles / Ulcers	YES NO <input type="checkbox"/> <input type="checkbox"/> Chest Pains <input type="checkbox"/> <input type="checkbox"/> Easily Winded <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Hay Fever / Allergies <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> <input type="checkbox"/> Other _____	COMMENTS <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
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### PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> YES <input type="checkbox"/> NO 3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> YES <input type="checkbox"/> NO 4. Do you feel pain to any of your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO 5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> YES <input type="checkbox"/> NO 6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO 7. Have you ever experienced any of the following problems in your jaw? a) Clicking? <input type="checkbox"/> YES <input type="checkbox"/> NO b) Pain (Joint, ear, side of face)? <input type="checkbox"/> YES <input type="checkbox"/> NO c) Difficulty in opening or closing? <input type="checkbox"/> YES <input type="checkbox"/> NO d) Difficulty in chewing? <input type="checkbox"/> YES <input type="checkbox"/> NO	8. Do you have frequent headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO 9. Do you clench or grind your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO 10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> YES <input type="checkbox"/> NO 11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO 12. Have you had any orthodontic treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO 13. Have you ever had prolonged bleeding following extractions? <input type="checkbox"/> YES <input type="checkbox"/> NO 14. Have you ever had instruction on the correct method of brushing your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO 15. Have you ever had instructions on the care of your gums? <input type="checkbox"/> YES <input type="checkbox"/> NO
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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.

**SIGNATURE**

**X**

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PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
DATE