

Patient Medical History

Patient Name _____

Are you ALLERGIC to or have you had any REACTIONS to the following:
(please check if yes)

- Penicillin, Amoxicillin?
- Clindamycin, Keflex, Cipro, Erythromycin?
- Codeine or other pain prescriptions?
- Aspirin, (Advil) Ibuprofen, or (Tylenol) Acetaminophen?
- Dental Anesthetics?
- Latex or rubber products?
- Any Metals (e.g. nickel, silver, gold, platinum, titanium)?
- Sulfa Drugs, Iodine?
- Barbituates, Sedatives, (Halcion, Valium)?
- Other (drugs or foods)? _____
- Steroids / Cortisone?
- Are you taking any naturopathic (holistic) remedies, vitamins or herbal supplements? _____
- List all current Physicians: _____

- Do you regularly take (Rx blood thinners?) or (Aspirin, Motrin, Advil) _____
- Are you under medical treatment now? _____
- Have you been hospitalized for surgery or illness recently?
- Have you had joint replacement surgery? What? _____ Year? _____
- Has your physician or dentist suggested you be pre-medicated for Dental work?
Recommended Pre-Med Rx: _____
- List any other prescriptions and non-prescription drugs you are taking regularly? _____
- Do you use controlled substances?
- Do you use tobacco?
Women Only:
 - Are you pregnant or think you may be pregnant?
 - Are you nursing?
 - Are you taking oral contraceptives?

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> AIDS or HIV Infection |
| <input type="checkbox"/> Anginal/Chest Pain | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis / Jaundice |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Anemia | <input type="checkbox"/> Steroids / Cortisone | <input type="checkbox"/> Fever Blisters / Herpes / Shingles |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Hay Fever / Allergies |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting / Seizures |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stomach Troubles / Ulcers |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy / Convulsions |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Glaucoma |
- Do you have any other diseases, conditions or problems not listed here that you think the doctor should know about? If yes please specify below: _____

Patient Dental History

Name of Previous Dentist and Location _____ Last Exam _____

- Do your gums bleed while brushing or flossing?
- Are your teeth sensitive to hot or cold liquids / foods?
- Are your teeth sensitive to sweet or sour liquids / foods?
- Do you feel pain/discomfort to any of your teeth?
- Have you had any head, neck or jaw injuries?
- Have you ever experienced problems or pain in your jaw?
- Do you have frequent headaches?
- Do you clench or grind your teeth?
- Do you wear or have you worn a night guard?
- Do you have a dry mouth? If so please explain? _____
- Have you had any orthodontic treatment? When? _____
- Do you wear Dentures or Partials?
If yes, date of original placement _____
Date of most recent placement _____
- Have you considered bleaching your teeth?
- Have you bleached your teeth in the past?
- Are you happy with your smile?
- Have you considered replacing your old silver fillings?
- Do you know about Dental procedures available to improve your smile?

Patient Health Responsibilities:

I have read and understand the above information to the best of my knowledge and realize that providing incorrect information can be dangerous to my health. I certify that the above questions have been accurately answered.

In order to achieve optimum results a cooperative effort is required. Once a treatment plan has been established, it is the patient's responsibility to follow instructions provided involving follow up care and appointments. A mutual respect and consideration among Dr. Cebrynski, patients and staff is required to achieve our common goals.

Patient / Guardian Signature _____ Date _____

Reviewed by Doctor _____ Date _____