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