Anita W. Elliott, D.D.S., P.C.

Elliot Dental Corporation

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? _____ Is your tooth brush pink 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 had 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 _____