PATIENT MEDICAL HISTORY

Patient's Name ____ **Date of Birth:** ______________________________________

Although Dental Personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the Dentistry that you will be receiving. Thank you for answering the following questions.

	YES	**NO**
1. Are you in good health?		
2. Have there been any changes in your general health within the past year?		
3. Date of your last physical exam. _____________		
4, Physician's name: ____		
5. Are you under the care of a physician?		
6. Have you ever been hospitalized for any surgical operation or serious illness? Yes ___ No ___ Please explain: ____________________ ____		
7. Are you taking any medicine(s) including non-prescription? If yes, please list medicines you are taking: ____ ____		
8. Have you had any abnormal bleeding?		
9. Do you bruise easily?		

	YES	**NO**
10. Have your ever required a blood transfusion?		
11. Have you had a recent weight loss?		
12. Have you ever taken Fen-Phen/Redux?		
13. Do you use tobacco?		
14. Do you or have you used/abused controlled substances?		
15. Are you wearing contact lenses?		
16. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
17. Do you have any disease, condition or problem not listed here that you think I should know about?		
WOMEN ONLY:		
Are you pregnant?		
Do you think you may be pregnant?		
Are you nursing?		
Are you taking birth control pills?		

	YES	**NO**
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:		
Local Anesthetics (i.e. novocaine)?		
Penicillin or other antibiotics?		
Sulfa Drugs?		
Barbiturates, sedatives or sleeping pills?		
Aspirin		
Iodine		
Any metals (i.e. Nickel, Mercury, etc.)		
Latex/Rubber		
Others (Please list): ______________________________________		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?		
Rheumatic Heart Disease or Rheumatic Fever		
Scarlet Fever		
Heart Murmur		
Heart Attack/Angina		
Chest Pain		
Shortness of Breath		
Pacemaker		
Heart Surgery		
High Blood Pressure		
Low Blood Pressure		
Congenital Heart Problem		
Swelling of feet and ankles		
Hepatitis, Jaundice or Liver Disease		
Stroke		
Sinus Trouble		
Lung or Breathing Problems		
Asthma or Hay Fever		

	YES	**NO**
Hives or skin rash?		
Fainting or dizzy spells?		
Diabetes?		
Aids or HIV infection		
Thyroid Problems		
Allergies		
Arthritis or Reumatism		
Joint Replacement or implant		
Stomach Ulcer		
Kidney Trouble		
Tuberculosis		
Persistent Cough		
Sexually Transmitted Disease		
Epilepsy or Seizures		
Anemia		
Glaucoma		
Nervousness		
Tonsillitis		
Tumors		
Mental Health Care		
Back Problems		
Chemical Dependency		
Mitral Valve Prolapse		
Cortisone Treatment		
Cold Sores/Fever Blisters		
Hypoglycemia		
Eating Disorders		

DO YOU NOW, OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING? NO _____ If yes please check :

Boniva ___ Fosamax ___ Actonel ___ Zoneta ___ Reclast ___ IV Biophosphnates ___

PATIENT DENTAL HISTORY

Patient Name: ______________________________ Date of Birth: ______________________

Reason for this visit? ____

When was your last dental visit? ______________ What was done at that visit? ________________________

Previous Dentist (Name and Location): ____

How often do you brush your teeth? __________________ How often do you floss your teeth? _______________

Is your drinking water fluoridated? _______ When/where were your last dental x-rays taken? ___________________

	YES	NO
Do your gums bleed while brushing or flossing?		
Are your teeth sensitive to hot or cold liquids or foods?		
Are your teeth sensitive to sweet or sour liquids or foods?		
Do you feel pain in any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any head, neck or jaw injuries?		
Have you ever experienced any of the following problems in your jaw?: Clicking __ Pain (joint, ear, side of face) __ Difficulty opening or closing __ Difficulty chewing ___		
Do you have frequent headaches?		
Do you clench or grind your teeth?		

	YES	NO
Do you bite your lips or cheeks frequently?		
Are any of your teeth loose?		
Does food tend to become caught between your teeth?		
Have you had periodontal (gum) treatment?		
Have you ever worn a bite plate or appliance?		
Have you had any difficult extractions?		
Have you had any prolonged bleeding after ext's?		
Do you wear dentures or partials? If yes, date of placement: _______________		
Have you ever received oral hygiene instructions?		

If you could change anything about your smile, what would you change?________________________________

____

Authorization and Release

I certify that I have read and answered 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. I authorize Dr. Koebley to release any information used for the diagnosis and treatment or examination rendered to me or my child during the periods of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Kevin B. Koebley, D.D.S., P.A. , insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents within 30 days of treatment.

____ Date: ____________________

Signature of responsible party.