BAY COSMETIC DENTISTRY
JEFFREY V. SCHROEDER, D.D.S.
RICHARD P. SABLE, D.D.S.
MICHAEL R. SCHER, D.D.S.

PATIENT MEDICAL HISTORY

NAME ______________________ ______________ ____________________________ **DOB** ___/___/___
FIRST MIDDLE LAST

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health issues that you may have or medication that you may be takins could have an important interrelationship with the dentistry that you will be receiving. Your responses to the following questions will assist us in providing the best care.

		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 ______________________ Address ______________________ Phone Number ______________________		
5.	Are you currently under the care of a physician?	☐	☐
6.	Have you ever been hospitalized for any surgical operation or serious illness? If YES, please explain: ______________________	☐	☐
7.	Are you taking any medications including non-prescription medications? If YES, what medications are you taking: ______________________	☐	☐
8.	Have you had any abnormal bleeding?	☐	☐
9.	Do you bruise easily?	☐	☐
10.	Have you ever required a blood transfusion?	☐	☐
11.	Have you had recent unexplained weight loss or gain?	☐	☐
12.	Have you ever taken Fen-Phen/Redux?	☐	☐
13.	Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
14.	Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?	☐	☐
15.	Do you use tobacco?	☐	☐
16.	Do you or have you used controlled substances?	☐	☐
17.	Are you wearing contact lenses?	☐	☐
18.	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
19.	Do you have any disease or condition not listed that you believe we should be aware of?	☐	☐
WOMEN ONLY			
20.	Are you pregnant or think you may be pregnant?	☐	☐
21.	Are you nursing?	☐	☐
22.	Are you taking birth control pills?	☐	☐

If you could change anything about your smile, what would it be? ______________________

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3716 W. Neptune, Tampa, FL 33629
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NAME ____________ ____________ ____________ **DOB** ___/___/___
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Are you allergic to or have you had reactions to:

	YES	NO
Local anesthetics like novocaine	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Asprin	☐	☐
Iodine	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex / Rubber	☐	☐

Other (Please List) ____________

Do you have or have you ever had the following:

	YES	NO
Rheumatic heart disease or rheumatic fever	☐	☐
Scarlet fever	☐	☐
Heart defect or murmur	☐	☐
Heart trouble, heart attack, or angina	☐	☐
Chest pain / Shortness of breath	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
High/Low blood pressure	☐	☐
Congenital heart problem	☐	☐
Swelling of feet, ankles, hands	☐	☐
Hepatitis, Jaundice, or liver disease	☐	☐
Stroke	☐	☐
Sinus trouble	☐	☐
Lung and/or breathing problems	☐	☐
Asthma or hay fever	☐	☐
Cold sores / Fever blisters	☐	☐
Eating disorder	☐	☐

	YES	NO
Hives or skin rash	☐	☐
Fainting or dizzy spells	☐	☐
Diabetes	☐	☐
AIDS or HIV infection	☐	☐
Thyroid problems	☐	☐
Allergies	☐	☐
Arthritis or rheumatism	☐	☐
Joint replacement or implant	☐	☐
Stomach ulcer	☐	☐
Kidney trouble	☐	☐
Tuberculosis	☐	☐
Persistent cough	☐	☐
Cough that produces blood	☐	☐
Chemotherapy (Cancer, Leukemia)	☐	☐
Sexually transmitted disease	☐	☐
Epilepsy or seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Nervousness	☐	☐
Tonsillitis	☐	☐
Tumors	☐	☐
Mental health care	☐	☐
Back problems	☐	☐
Chemical dependency	☐	☐
Mitral valve prolapse	☐	☐
Cortisone treatment	☐	☐
Hypoglycemia	☐	☐

Reason for this visit? ____________

When was your last dental visit? ____________

How often did you visit the dentist before then? ____________

Previous dentist (Name & Location) ____________

Have you had a complete series of dental X-Rays taken? ☐ YES ☐ NO

If YES, when & where? ____________

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NAME ______________ ______________ ______________ **DOB** ___/___/___
FIRST MIDDLE LAST

How often do you brush your teeth? ______________

How often do you floss your teeth? ______________

Is your drinking water fluoridated? ☐ YES ☐ NO

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquid/food?	☐	☐
Are your teeth sensitive to sweet or sour liquid/food?	☐	☐
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 in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐

	YES	NO
Do you frequently bite your lips or cheeks?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐
Does food tend to become caught in your teeth?	☐	☐
Have you ever had periodontal treatment (gums)?	☐	☐
Ever worn a bite plate or other appliance?	☐	☐
Have you ever had any difficult extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement: ___/___/___		
Have you ever received oral hygiene instructions regarding the care of your teeth & gums?	☐	☐

AUTHORIZATION & RELEASE: 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. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services rendered on my behalf or my dependents.

______________________________ ______________________
Signature of patient (Parent/Guardian if minor) Date

DOCTOR'S COMMENTS ______________________________

____

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Signature: ______________________________ Date ______________

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