Patient History

Date _____

Name _____

City/State/Zip _____

Phone _____ Sex _____ Age _____

List any surgeries/hospitalizations you have had _____

_____

_____

List prescriptions you are currently taking _____

_____

_____

List supplements & over-the-counter medications you are currently taking _____

_____

_____

_____

List any complaints about your health _____

_____

_____

Have you ever been diagnosed with a disease? If so, specify. _____

_____

Do you have: ___ silver fillings? ___ white fillings? ___ root canals? ___ crowns? ___extracted teeth (including wisdom teeth)? Have you ever had braces? _____

Do you have any allergies to drugs or food? If so, specify. _____

_____

Do you smoke? _____ Do you drink coffee? _____