Jennifer Pichardo, DDS, PC

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Today's Date _____
Name_____ Date of Birth _____
Home Address_____ Social Security Number_____
City, State Zip_____ Home Phone _____
Email Address _____ Business Phone _____

Patient Medical History

1. Are you under medical treatment now?
Yes ☐ No ☐
2. Have you ever been hospitalized for any surgical operation or serious illness?
Yes ☐ No ☐
3. Are you taking any medication(s) including non-prescription medicine? Yes ☐ No ☐
If yes, which medication(s)? _____
4. Do you use tobacco? Yes ☐ No ☐
5. Do you use alcohol, cocaine or other drugs? Yes ☐ No ☐
6. Are you wearing contact lenses? Yes ☐ No ☐
7. Are you allergic to or have you had any reactions to the following:

Local Anesthetics (e.g. Novocain)	Yes ☐	No ☐
Penicillin or other antibiotics	Yes ☐	No ☐
Sulfa Drugs	Yes ☐	No ☐
Barbiturates	Yes ☐	No ☐
Sedatives	Yes ☐	No ☐
Iodine	Yes ☐	No ☐
Aspirin	Yes ☐	No ☐
Other	Yes ☐	No ☐

8. *Women Only:*

a) Are you pregnant?	Yes ☐	No ☐
b) Are you nursing?	Yes ☐	No ☐
c) Are you taking birth control pills?	Yes ☐	No ☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Attack	☐	☐
Rheumatic Fever	☐	☐	Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐	Asthma	☐	☐
Low Blood Pressure	☐	☐	Leukemia	☐	☐
Epilepsy/Convulsions	☐	☐	Diabetes	☐	☐
Kidney Diseases	☐	☐	AIDS/HIV	☐	☐
Thyroid Problem	☐	☐	Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐	Heart Murmur	☐	☐
Frequently Tired	☐	☐	Angina	☐	☐
Emphysema	☐	☐	Anemia	☐	☐
Cancer	☐	☐	Arthritis	☐	☐
Hepatitis/Jaundice	☐	☐	Chest Pains	☐	☐
Stomach Troubles/Ulcers	☐	☐	Stroke	☐	☐
Sexually Transmitted Disease	☐	☐	Glaucoma	☐	☐
Hay Fever/Allergies	☐	☐	Easily Winded	☐	☐
Joint Replacement/Implant	☐	☐	Tuberculosis	☐	☐
Radiation Therapy	☐	☐	Liver Disease	☐	☐
Recent Weight Loss	☐	☐	Heart Trouble	☐	☐
Respiratory Problems	☐	☐	Other_____	☐	☐

Physician_____
Office Phone_____
Date of Last Exam_____
Emergency Contact Name_____
Emergency Contact Number_____

Patient Dental History

1. Do your gums bleed while brushing or flossing? Yes ☐ No ☐
2. Are your teeth sensitive to hot or cold liquids/foods? Yes ☐ No ☐
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes ☐ No ☐
4. Do you feel any pain to any of your teeth? Yes ☐ No ☐
5. Do you have any sores or lumps in or near your mouth? Yes ☐ No ☐
6. Have you had any head, neck, or jaw injuries? Yes ☐ No ☐
7. Have you ever experienced any of the following problems in your jaw?

	Yes	No
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

8. Do you have frequent headaches? Yes ☐ No ☐
9. Do you clench or grind your teeth? Yes ☐ No ☐
10. Do you bite your lips or cheeks frequently? Yes ☐ No ☐
11. Have you ever had any difficult extractions in the past? Yes ☐ No ☐
12. Have you had any orthodontic work? Yes ☐ No ☐
13. Have you ever had prolonged bleeding following extractions? Yes ☐ No ☐
14. Have you ever had instruction on the correct method of brushing your teeth? Yes ☐ No ☐
15. Have you ever had instructions on the care of your gums? Yes ☐ No ☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.
Signed_____ Date_____