Joseph E. Sheehan D.D.S., P.C.
General Family Dentistry

155 Dow Street, Suite 401
Manchester, NH 03101-1216
603-623-0641

PATIENT MEDICAL & DENTAL HISTORY — *Confidential*

Patient Name:_____ Birth Date:_____

MEDICAL HISTORY

Physician's Name:_____ Office Phone:_____ Date of Last Exam:_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain_____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g., novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g., nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐
10. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

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

DENTAL HISTORY

Name and Location of Previous Dentist:_____ Date of Last Exam:_____

	Yes	No
1. Do your gums bleed while you brush or floss?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever had any of the following jaw problems?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty opening or closing?	☐	☐
Difficulty chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had any difficult extractions in the past?	☐	☐
12. Have you ever had prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, what was the date of placement?_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have answered the above questions accurately to the best of my knowledge and that providing incorrect information can be dangerous to my health. I authorize the dentist to release to third-party payers and/or health practitioners any information, including diagnoses and records of examination or treatment that are rendered to my dependent(s) or myself. 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 carrier may pay less than the actual bill for services, and I agree to pay for the remaining amount for all services rendered on behalf of my dependent(s) or myself.

Signature of patient (or parent, if patient is a minor)_____ Date_____

Doctor's Comments:_____

_____

_____ Signature:_____ Date_____

MEDICAL HISTORY UPDATE

Patient Name:____

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and medications have changed as follows (if no change, write "No change"):

Signature of Patient (or Guardian) Date

Update Reviewed by Dr.____________________

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and medications have changed as follows (if no change, write "No change"):

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