# HAMPTON SMILE DENTAL, P.L.L.C. • ROBERT J. SICURELLI, A.B.D.D.S.

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____
HOME ADDRESS _____ DATE OF BIRTH _____
_____ HOME PHONE _____
E-MAIL _____ CELL PHONE _____
EMPLOYER _____ BUSINESS PHONE _____
REFERRED BY _____ SS#/SIN _____

## PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

| | YES | NO |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? | ☐ | ☐ |
| If yes, what medication(s) are you taking? _____ | | |
| 4. Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| 5. Do you use tobacco? | ☐ | ☐ |
| 6. Do you use alcohol, cocaine or other drugs? | ☐ | ☐ |
| 7. Are you wearing contact lenses? | ☐ | ☐ |

8. Are you allergic to or have you had any reactions to the following?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Local anesthetics (eg. novocaine) | ☐ | ☐ | Barbiturates | ☐ | ☐ | Aspirin |
| ☐ | ☐ | Penicillin or other antibiotics | ☐ | ☐ | Sedatives | ☐ | ☐ | Other _____ |
| ☐ | ☐ | Sulfa Drugs | ☐ | ☐ | Iodine | | | _____ |

9. WOMEN ONLY:

| | YES | NO |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking birth control pills? | ☐ | ☐ |

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

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

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

### COMMENTS

_____
_____
_____
_____
_____
_____

Signature of Dentist Date

## PATIENT DENTAL HISTORY

| | YES | NO |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 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 experienced any of the following problems in your jaw? | | |
| 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? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you had any orthodontic treatment? | ☐ | ☐ |
| 13. Have you ever had prolonged bleeding following extractions? | ☐ | ☐ |
| 14. Have you ever had instruction on the correct method of brushing your teeth? | ☐ | ☐ |
| 15. Have you ever had instructions on the care of your gums? | ☐ | ☐ |

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.

**SIGNATURE** X _____ _____

PATIENT, PARENT OR GUARDIAN DATE



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