

## Patient Information Form

*Directions:* You are the patient. At home, fill out this form with your information.  
You do not need to share this with your instructor or the class.

1. Last name: \_\_\_\_\_  
First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_
  2. Street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip code: \_\_\_\_\_
  3. Date of birth: \_\_\_\_\_  
(month, day, year)
  4. Social Security Number: \_\_\_\_\_
  5. Marital status -- put a check mark (✓) on the correct blank:  
Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_
  6. Occupation/job: \_\_\_\_\_
  7. Employer's name: \_\_\_\_\_
  8. Employer's street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip code: \_\_\_\_\_
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**Patient Information Form, continued**

9. Last name of spouse: \_\_\_\_\_  
First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_
10. Spouse's Social Security Number: \_\_\_\_\_
11. Insurance provider name: \_\_\_\_\_
12. Name of holder of this insurance plan: \_\_\_\_\_
13. Relationship to patient: \_\_\_\_\_
14. Insurance Group # \_\_\_\_\_ ID #: \_\_\_\_\_
15. Emergency phone number: \_\_\_\_\_
16. Name of emergency contact: \_\_\_\_\_
17. Relationship to patient: \_\_\_\_\_
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## Patient Medical History Form

*Directions:* You are the patient. At home, fill out this form with your information.  
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1. Date of last medical exam (month, year) \_\_\_\_\_
2. Have you ever been hospitalized for surgery or serious illness? Yes \_\_\_ No \_\_\_  
If yes,

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Are you taking any medications (prescriptions or over-the-counter) regularly?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what medications are you taking?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Do you wear glasses or contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_
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**Patient Medical History Form, continued**

5. Are you allergic to any medication or have you had any reactions?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, fill out the chart below.

Name of Medication	Reaction	When

6. Are you allergic to anything else (food, pollen, dust, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_

7. Do you have or have you had any of the following:

- |                                     |           |          |
|-------------------------------------|-----------|----------|
| a. arthritis                        | Yes _____ | No _____ |
| b. diabetes                         | Yes _____ | No _____ |
| c. hypertension/high blood pressure | Yes _____ | No _____ |
| d. high cholesterol                 | Yes _____ | No _____ |
| e. mental illness                   | Yes _____ | No _____ |
| f. kidney disease                   | Yes _____ | No _____ |
| g. osteoporosis                     | Yes _____ | No _____ |
| h. sexual/physical abuse            | Yes _____ | No _____ |
| i. thyroid disease                  | Yes _____ | No _____ |
| j. HIV/AIDS                         | Yes _____ | No _____ |
| k. heart disease/heart attack       | Yes _____ | No _____ |
| l. substance abuse                  | Yes _____ | No _____ |
| m. alcoholism                       | Yes _____ | No _____ |
| n. asthma                           | Yes _____ | No _____ |
| o. seizures                         | Yes _____ | No _____ |

**Patient Medical History Form, continued**

- p. stroke Yes \_\_\_\_\_ No \_\_\_\_\_
- q. anemia/blood diseases Yes \_\_\_\_\_ No \_\_\_\_\_
- r. liver diseases Yes \_\_\_\_\_ No \_\_\_\_\_
- s. immune problems Yes \_\_\_\_\_ No \_\_\_\_\_
- t. cancer Yes \_\_\_\_\_ No \_\_\_\_\_
- u. frequently tired Yes \_\_\_\_\_ No \_\_\_\_\_
- v. recent weight loss Yes \_\_\_\_\_ No \_\_\_\_\_
- w. other:

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## 8. For Women Only

# pregnancies \_\_\_\_\_

# live births \_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_

Age periods began \_\_\_\_\_

First day of last period \_\_\_\_\_

Do you use birth control? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what kind? \_\_\_\_\_

## Patient Family History Form

*Directions:* You are the patient. At home, fill out this form with the patient's information. You do not need to share this with your instructor or the class.

Has anyone in your family ever had any of the following?

	Yes	No	If yes, who? (e.g., father, mother, sibling, son, daughter, grandparent, etc.)
arthritis			
diabetes			
hypertension/ high blood pressure			
high cholesterol			
mental illness			
kidney disease			
osteoporosis			
sexual/physical abuse			
thyroid disease			
HIV/AIDS			
heart disease/ heart attack			
substance abuse			

## Patient Family History Form, continued

	Yes	No	If yes, who? (e.g., father, mother, sibling, son, daughter, grandparent, etc.)
alcoholism			
asthma			
seizures			
stroke			
anemia/blood disease			
liver diseases			
immune problems			
cancer - fill in the blank for type: _____ _____ _____			
other disease - fill in the blank: _____ _____ _____			

## Patient Dental Form

*Directions:* You are the patient. At home, fill out this form with your information.  
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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 pain in 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:
    - a. Clicking? Yes \_\_\_ No \_\_\_
    - b. Pain (joint, ear, side of face)? Yes \_\_\_ No \_\_\_
    - c. Difficulty in opening or closing? Yes \_\_\_ No \_\_\_
    - d. Difficulty in chewing? Yes \_\_\_ No \_\_\_
  8. Do you have headaches often? Yes \_\_\_ No \_\_\_
  9. Do you clench or grind your teeth? Yes \_\_\_ No \_\_\_
  10. Do you bite your lips or cheeks often? Yes \_\_\_ No \_\_\_
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**Patient Dental Form**, continued

11. Have you ever had any difficult extractions in the past? Yes \_\_\_ No \_\_\_
12. Have you had any orthodontic treatment? 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 \_\_\_
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