Medical History

I consider my health to be (Please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you had any of the following? (Please circle Y for yes or N for no)

Y N Heart Disease
Y N Heart Murmur/ Valve Prolapse
Y N Do you have a Pace Maker
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Ulcers
Y N Abnormal Blood Pressure
Y N Anemia
Y N Tuberculosis or Lung Disease
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Epilepsy/Seizures
Y N Implants/Artificial Joints
Y N Prolonged Bleeding Disease
Y N Do you use alcohol or other drugs?
Y N I smoke or use tobacco. If yes, how much per day?_____ How many years?_____
Y N I usually take an antibiotic prior to dental treatment.
Y N Have you ever taken Fen-Phen or Redux?
Y N Have you ever taken Fosamax, Boniva, Actonel or any other cancer medication containing Bisphosphonates?

Y N Liver Disease
Y N Jaundice
Y N Hepatitis Type____
Y N Diabetes
Y N Excessive Urination and/or Thirst
Y N Herpes
Y N AIDS
Y N Infection Mononucleosis (Mono)
Y N Arthritis
Y N Sexually Transmitted/Venereal Disease
Y N Kidney Disease
Y N Tumor or Malignancy
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N History of Drug Addiction

Y N Immune Suppressed Disorder
Y N Hearing Loss
Y N Fainting Spells
Y N Glaucoma
Y N History of Emotional or Nervous Disorders

Women

Y N Are you taking Birth Control Medications?
Y N Are you or could you be pregnant or nursing

Doctors Notes Only:

Y N I have had major Surgery: Year_____ Type of operation_____ Year_____ Type of operation_____

Do you Have any other medical problem or medical history NOT listed on this form?_____

Are you allergic to any of the following?

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N Latex, Metals, Plastics
Y N Local Anesthetics (Novocaine)

Please list all medications you are currently taking:

Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Physician's Name_____ Phone_____

Dental Health

Why have you come in to see us today? (e.g.: pain, checkup, etc.)_____
When was your last dental visit/cleaning?_____
Have you had any problems with past dental treatment?_____
Are you nervous about seeing a dentist? (circle one) YES NO If yes, please tell us why:_____
How often do you brush? _____ Do you floss? (circle one) YES NO How often?_____

Y N Do you feel pain to any of your teeth
Y N Sensitive to hot/cold/sweet?
Y N My gums bleed while brushing or flossing
Y N My gums feel tender or swollen
Y N I clench or grind my teeth during the day or while sleeping
Y N I have problems eating
Y N Jaw pain or problems

Y N I have had facial or jaw injury
Y N Difficult /prolonged bleeding
Y N I have had orthodontics
Y N I want my teeth straight
Y N I want my teeth whiter
Y N I like my smile

What are you dental priorities?_____
(e.g.: dental health, cosmetic, financial considerations, etc.)

In the event of an emergency please contact:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

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.

X_____ ____/____/____
Signature of Patient (or parent/guardian if minor) Date

Periodic medical/dental heath reviewed by: (Office use only)

X_____ ____/____/____ X_____ ____/____/____
Doctor's Signature Date Patient's Signature Date

X_____ ____/____/____ X_____ ____/____/____
Doctor's Signature Date Patient's Signature Date

X_____ ____/____/____ X_____ ____/____/____
Doctor's Signature Date Patient's Signature Date