MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Your physician information:
Physician Name: _____
Office Phone Number: (_____) _____

Are you under physician's care now?	( ) Yes	( ) No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	( ) Yes	( ) No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	( ) Yes	( ) No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	( ) Yes	( ) No	If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux?	( )Yes	( ) No	_____
Are you on a special diet?	( ) Yes	( ) No	_____
Do you use tobacco?	( ) Yes	( ) No	
Do you use controlled substances?	( ) Yes	( ) No	

Women: Are you
( ) Pregnant/Trying to get pregnant? ( ) Nursing?
( ) Taking oral contraceptives?

Are you allergic to any of the following?
( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex
( ) Local Anesthetics ( ) Other
If yes, please explain: _____

Are you taking any of blood thinner medications?
If yes, please explain:
_____

Do you have, or have you had, any of the following?

( ) AIDS/HIV Positive	( ) Chest Pains	( ) Frequent Headaches	( ) Irregular Heartbeat
( ) Scarlet Fever	( ) Alzheimer's disease	( ) Cold Sores/Fever Blisters	( ) Genital Herpes
( ) Kidney Problems	( ) Shingles	( ) Anaphylaxis	( ) Leukemia
( ) Congenital Heart Disorder	( ) Glaucoma	( ) Leukemia	( ) Sickle Cell Disease
( ) Anemia	( ) Convulsions	( ) Hay Fever	( ) Liver Disease
( ) Sinus Trouble	( ) Angina	( ) Cortisone Medicine	( ) Diabetes
( ) Heart Attack/Failure	( ) Low Blood Pressure	( ) Spina Bifida	( ) Arthritis/Gout
( ) Heart Murmur	( ) Lung Disease	( ) Stomach Disease	( ) Stroke
( ) Artificial Heart Valve	( ) Drug Addiction	( ) Heart Pace Maker	( ) Artificial Joint
( ) Mitral Valve Prolapse	( ) Easily Winded	( ) Heart Trouble/Disease	( ) Pain in Jaw Joints
( ) Swelling of Limbs	( ) Asthma	( ) Emphysema	( ) Hemophillia
( ) Parathyroid Disease	( ) Thyroid Disease	( ) Blood Disease	( ) Hepatitis
( ) Epilepsy or Seizures	( ) Psychiatric Care	( ) Tonsillitis	( ) Herpes
( ) Blood Transfusion	( ) Excessive Bleeding	( ) Hepatitis B or C	( ) Cancer
( ) Radiation Treatments	( ) Tuberculosis	( ) Breathing Problem	( ) Excessive Thirst
( ) Recent Weight Loss	( ) Tumors/Growths	( ) Bruise Easily	( ) Ulcer
( ) Fainting Spells/Dizziness	( ) High Blood Pressure	( ) Renal Dialysis	( ) Rheumatism
( ) Frequent Cough	( ) Hives or Rash	( ) Rheumatic Fever	( ) Venereal Disease
( ) Chemotherapy	( ) Frequent Diarrhea	( ) Hypoglycemia	( ) Yellow Jaundice

Have you ever had any serious illness not listed above? ( ) Yes ( ) No

If yes, please explain:_____

DENTAL HISTORY

Date of Last Dental Visit: _____

1. How often you brush your teeth? _____
2. Do your gums bleed while brushing or flossing? ( ) Yes ( ) No If yes, please explain: _____
3. Are you currently experiencing any pain? ( ) Yes ( ) No If yes, please explain: _____
4. Are your teeth sensitive to hot or cold? ( ) Yes ( ) No If yes, please explain: _____
5. Are your teeth sensitive to sweet or sour? ( ) Yes ( ) No If yes, please explain: _____
6. Do you wear dentures or partials? ( ) Yes ( ) No If yes, please explain: _____
7. How would you rate your smile? ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10
8. Is anything you want to change about your smile? ( ) Yes ( ) No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____
Patient Last and First Name (Print)

_____ _____
Signature of Patient (Legal Guardian, if Minor) Date

_____ _____
Doctor's Signature Date