MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Address _____

Phone# (_____) _____ Date of Last Visit _____

Your Current Health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician ☐ Yes ☐ No

If Yes, Please explain:

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

ALLERGIES

Aspirin	Y	N	Erythromycin	Y	N	Sedatives	Y	N
Barbiturates	Y	N	Jewelry	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Latex	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Penicillin	Y	N	Other	Y	N

FOR WOMEN: Are you taking birth control pills? ☐Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No ☐ Unsure Week # _____

Are you Nursing? ☐Yes ☐ No

Are you taking any of the following

Acetaminophen	Y	N	Blood Thinners	Y	N	Insulin/Diabetes Drugs	Y	N	Thyroid Medicine	Y	N
Antibiotics	Y	N	Blood Pressure Meds	Y	N	Nitroglycerine	Y	N	Tranquilizers	Y	N
Antihistamines	Y	N	Cold Remedies	Y	N	Recreational Drugs	Y	N	Bisphosphonates (Fosfomax)	Y	N
Aspirin	Y	N	Digitalis/Heart Meds	Y	N	Steroids/Cortisone	Y	N			

Are you taking any prescription/over the counter drugs not listed? _____yes ____no Please list if yes _____

Do you or have you experienced the following

Abnormal Bleeding	Y	N	Colitis	Y	N	Headaches	Y	N	Liver Disease	Y	N	Shingles	Y	N
Alcohol Abuse	Y	N	Seizures	Y	N	Heart Attack	Y	N	Low Blood Pressure	Y	N	Sickle Cell Disease	Y	N
Anemia	Y	N	Diabetes	Y	N	Heart Murmur	Y	N	Lupus	Y	N	Sinus Problems	Y	N
Arthritis	Y	N	Difficulty Breathing	Y	N	Heart Surgery	Y	N	Mitral Valve Prolapse	Y	N	Stroke	Y	N
Artificial Joints	Y	N	Drug abuse	Y	N	Hemophilia	Y	N	Pacemaker	Y	N	Thyroid Problems	Y	N
Artificial Heart Valves	Y	N	Emphysema	Y	N	Hepatitis	Y	N	Persistent Cough	Y	N	Tonsillitis	Y	N
Asthma	Y	N	Epilepsy	Y	N	Herpes	Y	N	Psychiatric Problems	Y	N	Tuberculosis	Y	N
Blood Transfusion	Y	N	Fainting Spells	Y	N	High Blood Pressure	Y	N	Radiation Treatment	Y	N	Ulcers	Y	N
Cancer	Y	N	Fever Blisters	Y	N	HIV+ /AIDS	Y	N	Rheumatic Fever	Y	N	Venereal Disease	Y	N
Chemotherapy	Y	N	Glaucoma	Y	N	Hospitalizations	Y	N	Scarlet Fever	Y	N	Chicken Pox	Y	N
Hay Fever	Y	N	Kidney Problems	Y	N	Congenital Heart Defects	Y	N						

DENTAL HISTORY

Why have you come to the dentist today?:

Are you currently in pain.? ☐Yes ☐No

Do you require antibiotics before dental treatments? ☐Yes ☐No

Have you experienced problems associated with any work? ☐Yes ☐No

Do you now or have you ever experienced pain or discomfort in you jaw joint (TMD/TMJ)? ☐Yes ☐No

Do you Floss Daily? ☐Yes ☐No

What type of toothbrush do you use? ☐Hard ☐Med ☐Soft

Do you use any other oral hygiene aids? ☐Yes ☐No

Are you concerned with overly bad breadth? ☐Yes ☐No

Are you concerned with overly dark teeth? ☐Yes ☐No

Do your Gums Bleed? ☐Yes ☐No

Have you ever had Periodontal Disease? ☐Yes ☐No

Are any of your teeth loose ? ☐Yes ☐No

Are your teeth sensitive to heat, cold or anything else? ☐Yes ☐No

Do you still have your wisdom teeth? ☐Yes ☐No

Reason for leaving your last dentist:

Have you been seen by a dental specialist within the last 5 years? ☐Yes ☐No

Who?

What do you like most and least about any dentist you have seen?

Are you happy with the way your teeth look and feel? ☐Yes ☐No

If not, what would you change?

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the stricktest confidence within HIPPA guidelines and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need . I understand that if I cancel within 24 hours of my next appointment there will be a fee and that payment is due at the time of service.

Signature (or guardian) _____ Date _____