Medical - Dental History Form

Family Physician: _____
Medical Alerts: _____
Are you now or have you recently been under a physician's care? __ Yes __ No
Reason: _____
Have you ever been a patient in a hospital or had any serious illness? _____
Explain: _____

Check any of the following that you have had or suspected:

Yes	No		Yes	No		Yes	No	
___	___	Lung Disease	___	___	Hepatitis or Jaundice	___	___	Stroke
___	___	Rheumatic Fever	___	___	Prosthetic Joint Replacement	___	___	Epilepsy
___	___	Prolonged Bleeding	___	___	High/ Low Blood Pressure	___	___	Glaucoma
___	___	Kidney/ Bladder Trouble	___	___	Radiation Treatment	___	___	Anemia
___	___	Cancer or Tumor	___	___	Blood Transfusion	___	___	Chest Pain
___	___	Shortness of Breath	___	___	Fainting Tendency	___	___	Diabetes
___	___	Liver Disease	___	___	Asthma or Hay Fever	___	___	HIV/AIDS
___	___	Heart Murmur	___	___	Heart Trouble	___	___	Arthritis
___	___	Heart Trouble	___	___	Sinus Trouble			
___	___	Tuberculosis	___	___	Lung Disease			
___	___	Venereal Disease	___	___	Blood Disease			
___	___	Thyroid Disease	___	___	Mental Disorders			

Check any of the following that you are taking or have taken:

Yes	No		Yes	No		Yes	No	
___	___	Cortisone Drugs	___	___	Anticoagulants	___	___	Steroids
___	___	Tranquilizers	___	___	Blood Thinners	___	___	Sedatives

Are you taking any other medications? __Yes __ No
If yes, please explain?

_____
_____

Are you allergic to or do you suffer ill effects from any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Penicillin	___	___	Dental Anesthesia	___	___	Codeine
___	___	Household Bleach	___	___	Other: _____	___	___	Aspirin

Women Only:
Are you pregnant? __Yes __ No If yes: How many months? ___ Are you breast feeding? ___
Are you presently taking medicine of any kind routinely? (Birth control, pills, shots or implant, hormone therapy, etc.) Explain:

_____
_____

1.) What is your most important dental issue?

_____
_____

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2.) Are you satisfied with the appearance of your smile? If not, what concerns do you have?

_____

_____