MICHAEL P. FLEITZ, D.D.S. • JEFFREY A. TILSON, D.D.S.

Patient's Name _____ Date of Birth _____

## MEDICAL HISTORY

Do you have a personal physician? ❑Yes ❑No

Physician's Name: _____

Address: _____

Phone # _____ Date of last visit: _____

**Your current physical health is: ❑Good ❑Fair ❑Poor**

Are you currently under the care of a physician?

Please explain: _____

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

Have you had any metal rods, pins or implants? ❑Yes ❑No

Are you taking any medications? ❑Yes ❑No

Please list each one: _____

_____

_____

_____

**Have you ever had any of the following diseases or medical problems?**

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Surgery
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV or AIDS
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Trait
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers
Y N Venereal Disease

Please list any serious medical conditions that you have ever had:

_____

_____

**Are you allergic to any of the following:**

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Epinephrine
Y N Jewelry/Metals
Y N Latex
Y N Penicilin
Y N Tetracycline
Y N Other

Please list any other drug/materials that you are allergic to: _____

_____

**For Women:** Are you taking birth control pills? ❑Yes ❑No

Are you pregnant? ❑Yes ❑No Week #_____

Are you nursing? ❑Yes ❑No

## DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ❑Yes ❑No

Are you currently in pain? ❑Yes ❑No

Have you ever had a serious/difficult problem with any previous dental work? ❑Yes ❑No

Have you ever had gum disease? ❑Yes ❑No

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

Any unfavorable dental experiences? ❑Yes ❑No

Are you happy with the color of your teeth? ❑Yes ❑No

**Your current dental health is: ❑Good ❑Fair ❑Poor**

Do you like your smile? ❑Yes ❑No

Do your gums bleed? ❑Yes ❑No

How many times do you: floss/week?_____brush/day?_____

Are your teeth sensitive to heat, cold or anything else?_____

Have you lost any teeth? ❑Yes ❑No

If so, why?_____

Notes: _____

_____

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.**

_____ _____

Signature Date

**I verbally reviewed the medical/dental information above with patient named herein.**

**Doctor's Initials:_____ Date:_____**

## MEDICAL HISTORY UPDATES

Date:_____Comments:_____Initials:_____

Date:_____Comments:_____Initials:_____

Date:_____Comments:_____Initials:_____

Date:_____Comments:_____Initials:_____

Date:_____Comments:_____Initials:_____

Date:_____Comments:_____Initials:_____