

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

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

Are you allergic to any of the following:

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

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: _____