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 all your medications and herbal supplements:

_____
_____
_____
_____

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

Y N Abnormal Bleeding
Y N Alcohol/Drug Use
Y N Anemia
Y N Arthritis
Y N Artificial Bones/ joints/ Valves
Y N Asthma
Y N Blood Transfusions
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/Yellow Jaundice
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 Osteoporosis
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 Tumors or Growths
Y N Ulcer/ Stomach Disease
Y N Venereal Disease/STD

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

_____
_____

For Women:
Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

Why have you come to the dentist today? _____
_____
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
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
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? _____
_____

Are you allergic to any of the following?

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

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

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 changed in my medical status.

_____ _____
Patient/Guardian Signature Date

I verbally reviewed the medical/dental information

Doctor's Initials: _____ Date: _____