

# 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

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 esthetics	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

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					

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	Stoke	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								

# DENTAL HISTORY

Why have you come to the dentist today?:

Are you currently in pain.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat, cold or anything else? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you require antibiotics before dental treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced problems associated with any work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for leaving your last dentist:
Do you now or have you ever experienced pain or discomfort in you jaw joint (TMD/TMJ)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been seen by a dental specialist within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you Floss Daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who?
What type of toothbrush do you use? <input type="checkbox"/> Hard <input type="checkbox"/> Med <input type="checkbox"/> Soft	What to you like most and least about any dentist you have seen?
Do you use any other oral hygiene aids? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you happy with the way your teeth look and feel? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you concerned with overly bad breadth? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what would you change?
Are you concerned with overly dark teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do your Gums Bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had Periodontal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are any of your teeth loose ? <input type="checkbox"/> Yes <input type="checkbox"/> No	

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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 \_\_\_\_\_