

MEDICAL HISTORY

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

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

Are you taking any prescription drugs? Yes No

Please list: _____

Have you ever taken Phen-Fen or Redux? Yes No

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

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

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

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

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Other
Y N Codeine	Y N Latex	
Y N Dental Anesthetics	Y N Penicillin	

Please list any drugs that you are allergic to: _____

MEDICAL HISTORY CONTINUED

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____

Phone#:() _____ Date of last visit: _____

DENTAL HISTORY

What is your primary dental concern(s)?

Do you need to be premedicated before dental treatment? Yes No

Are you currently in pain? Yes No

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

Have you ever had periodontal treatment? Yes No

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

Your current dental health is: Good Fair Poor

Do your gums ever bleed? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of brushes? Hard Medium Soft

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

Do you like your smile? Yes No

Please explain: _____

I 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 _____

AREA BELOW THIS LINE IS FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. Signature _____ Date _____