MEDICAL HISTORY

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ❑ Yes ❑ No If yes, please explain: _____

_____

_____

Women: Are you
Pregnant/Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics
❑ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive _____	Diabetes _____	Hepatitis A _____	Rheumatic Fever _____
Alzheimer's Disease _____	Drug Addititious _____	Hepatitis B or C _____	Rheumatism _____
Anaphylaxis _____	Easily Winded _____	Herpes _____	Scarlet Fever _____
Anemia _____	Emphysema _____	High Blood Pressure _____	Shingles _____
Angina _____	Epilepsy or Seizures _____	High Cholesterol _____	Sickle Cell Disease _____
Arthritis/Gout _____	Excessive Bleeding _____	Hives or Rash _____	Sinus Trouble _____
Artificial Heart Valve _____	Excessive Thirst _____	Hypoglycemia _____	Spina Bifida _____
Artificial Joint _____	Fainting Spells/Dizziness _____	Irregular Heartbeat _____	Stomach/Intestinal Disease _____
Asthma _____	Frequent Cough _____	Kidney Problems _____	Stroke _____
Blood Disease _____	Frequent Diarrhea _____	Leukemia _____	Swelling of Limbs _____
Blood Transfusion _____	Frequent Headaches _____	Liver Disease _____	Thyroid Disease _____
Breathing Problem _____	Genital Herpes _____	Low Blood Pressure _____	Tonsillitis _____
Bruise Easily _____	Glaucoma _____	Lung Disease _____	Tuberculosis _____
Cancer _____	Hay Fever _____	Mitral Valve Prolapse _____	Tumors or Growths _____
Chemotherapy _____	Head or Neck Injury _____	Pain in Jaw Joints _____	Ulcers _____
Chest Pains _____	Heart Attack/Failure _____	Parathyroid Disease _____	Venereal Disease _____
Cold Sores/Fever Blisters _____	Heart Murmur _____	Psychiatric Care _____	Yellow Jaundice _____
Congenital Heart Disorder _____	Heart Pace Maker _____	Radiation Treatments _____	
Convulsions _____	Heart Trouble/Disease _____	Recent Weight Loss _____	
Cortisone Medicine _____	Hemophilia _____	Renal Dialysis _____	

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain: _____

_____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

Check if you have had any of the following:

___ Bad Breath
___ Bleeding gums
___ Unpleasant taste
___ Food Impaction
___ Smoking or tobacco use
Tooth sensitivity to:
___ Cold
___ Hot
___ Sweets
___ Biting
___ Clicking or popping jaw
___ Pain around jaw or ear
___ Clenching or grinding
___ Dry mouth
___ Burning sensation on tongue
___ Blisters on lips or mouth
___ Swelling or lumps in mouth
___ Loose teeth or broken fillings
___ Oral habits/ Fingernail biting, cheek biting, etc.
___ Mouth pain, brushing
___ Gums swollen or tender
___ Orthodontic treatment
___ Oral surgery
___ Periodontal treatment
How often do you brush? _____
How often do you floss? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____