

MEDICAL HISTORY

Your current physical health is: Good Fair Poor

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

Please explain: _____

Are you taking any prescription/over the counter drugs? Please list each one: _____

Do you have a personal physician? Yes No

Physician's Name: _____

Phone Number: _____ Date of last visit: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (circle)

Y N Asthma/Arthritis	Y N Kidney Problems
Y N Anemia/Radiation	Y N High/Low Blood Pressure
Y N Blood Transfusion	Y N Psychiatric Problems
Y N Cancer/Chemotherapy	Y N Severe/Frequent Headaches
Y N Congenital Heart Defect	Y N Shingles
Y N Diabetes	Y N Sinus Problems
Y N Difficulty Breathing	Y N Stroke
Y N Drug/Alcohol Abuse	Y N Tuberculosis (TB)
Y N Emphysema	Y N Venereal Disease
Y N Epilepsy/Seizure	Y N Artificial Bone/Joints
Y N Fever Blisters/Herpes	Y N Artificial Valves
Y N Glaucoma	Y N Heart Attack
Y N Hemophilia/Abnormal bleeding	Y N Heart Murmur
Y N Hepatitis	Y N Heart surgery/pacemaker
Y N HIV+/AIDS	Y N Mitral Valve Prolapse
Y N Hospitalized for any Reason	Y N Rheumatic/Scarlet Fever

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

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex
<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Other _____

FOR WOMEN:

Are you taking birth control pills? Yes No

Type of birth control: _____

Are you pregnant? Yes No

Week #: _____

Are you nursing? Yes No

DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? Yes No

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

Do you like to smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____

Have you had previous periodontal treatment? Yes No

If so, when and what? _____

IN THE EVENT OF AN EMERGENCY, WHO MAY WE CONTACT?

Name: _____ Relation: _____

Work#: _____ Home #: _____

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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature (If patient is under 18, parent or guardian) _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

– OFFICE USE ONLY –

I have verbally reviewed the medical/dental information above with the patient named herein.

Signature: _____ Date _____

Comments: _____

Signature: _____ Date _____

Comments: _____

Signature: _____ Date _____

Comments: _____

Signature: _____ Date _____

Comments: _____

Signature: _____ Date _____

Comments: _____