

DENTAL HISTORY

What is the reason for your visit today? _____
 Are your teeth sensitive to hot or cold? Yes No Pressure? Yes No Sweets? Yes No
 Do your gums bleed when you brush? Yes No Do you grind or clench your teeth? Yes No
 Who was your previous Dentist? _____ Date of last exam? _____
 How do you like your smile? _____ Do you have a fear of dentistry? Yes No

MEDICAL HISTORY

Has there been any changes in your general health within the last year? _____
 Have you been admitted to the hospital within the past two years? Yes No
 Are you currently under the care of a physician? Yes No Date of last physical Exam _____
 Physicians Name _____ Physicians Phone Number _____
 Are you currently taking any Over-the-counter or prescription medications? Yes No
 Please List: _____

Do you or have you ever had any of the following disease or medical conditions: Please Check Yes or No:

- | | | |
|---|--|---|
| A.I.D.S or HIV Infection..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Drug Dependency Yes <input type="checkbox"/> No <input type="checkbox"/> | Jaundice / Liver Disease Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Alcohol Abuse Yes <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy or Seizures Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Trouble..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Allergies or Hives..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Emphysema or COPD Yes <input type="checkbox"/> No <input type="checkbox"/> | Mitral Valve Prolapse Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis or Painful Joints Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma Yes <input type="checkbox"/> No <input type="checkbox"/> | Pacemaker Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Joints (hip, knee)..... Yes <input type="checkbox"/> No <input type="checkbox"/> | GERD / Acid Reflux Yes <input type="checkbox"/> No <input type="checkbox"/> | Respiratory Problems..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Heart Valve..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Defects / Murmur..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Radiation Therapy Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma / Hay Fever..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Disease / Attack..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Trouble/Surgery Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bruise Easily Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Surgery Yes <input type="checkbox"/> No <input type="checkbox"/> | Stomach Ulcers..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer Yes <input type="checkbox"/> No <input type="checkbox"/> | Hemophilia Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Problems Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chemotherapy..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis Yes <input type="checkbox"/> No <input type="checkbox"/> | Tobacco Use Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/> | High Blood Pressure Yes <input type="checkbox"/> No <input type="checkbox"/> | Tuberculosis Yes <input type="checkbox"/> No <input type="checkbox"/> |

Do you have any disease or condition not listed? _____
 Have you ever taken Phen-fen or Redux? _____

Are you allergic to any of the following: Please Check Yes or No

- | | | |
|--|---|---|
| Aspirin Yes <input type="checkbox"/> No <input type="checkbox"/> | Erythromycin Yes <input type="checkbox"/> No <input type="checkbox"/> | Dental Anesthetics Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Codeine Yes <input type="checkbox"/> No <input type="checkbox"/> | Penicillin Yes <input type="checkbox"/> No <input type="checkbox"/> | Jewelry/Metals Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Sulfa Drugs Yes <input type="checkbox"/> No <input type="checkbox"/> | Seafood Yes <input type="checkbox"/> No <input type="checkbox"/> | Latex Yes <input type="checkbox"/> No <input type="checkbox"/> |

List any other drugs/materials you are allergic to: _____

Women Only: Please Check Yes or No

- Are you pregnant? Yes No Are you Nursing? Yes No Are you taking birth control pills? Yes No
 Are you aware of the efficacy of the birth control pill when used in combination with antibiotics? Yes No

PROVIDED CONSENT

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:

Patient Signature _____ Date _____
 Responsible Party Signature _____ Relationship to Patient _____
 Doctors Signature _____ Date _____