Patient Name _____ **Date** _____

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 ❑ No ❑	Drug Dependency ..... Yes ❑ No ❑	Jaundice / Liver Disease ..... Yes ❑ No ❑
Alcohol Abuse ..... Yes ❑ No ❑	Epilepsy or Seizures..... Yes ❑ No ❑	Kidney Trouble..... Yes ❑ No ❑
Allergies or Hives..... Yes ❑ No ❑	Emphysema or COPD ..... Yes ❑ No ❑	Mitral Valve Prolapse ..... Yes ❑ No ❑
Arthritis or Painful Joints ..... Yes ❑ No ❑	Glaucoma ..... Yes ❑ No ❑	Pacemaker ..... Yes ❑ No ❑
Artificial Joints (hip, knee)..... Yes ❑ No ❑	GERD / Acid Reflux ..... Yes ❑ No ❑	Respiratory Problems..... Yes ❑ No ❑
Artificial Heart Valve..... Yes ❑ No ❑	Heart Defects / Murmer..... Yes ❑ No ❑	Radiation Therapy ..... Yes ❑ No ❑
Asthma / Hay Fever..... Yes ❑ No ❑	Heart Disease / Attack..... Yes ❑ No ❑	Sinus Trouble/Surgery ..... Yes ❑ No ❑
Bruise Easily ..... Yes ❑ No ❑	Heart Surgery ..... Yes ❑ No ❑	Stomach Ulcers..... Yes ❑ No ❑
Cancer..... Yes ❑ No ❑	Hemophilia ..... Yes ❑ No ❑	Thyroid Problems ..... Yes ❑ No ❑
Chemotherapy..... Yes ❑ No ❑	Hepatitis ..... Yes ❑ No ❑	Tobacco Use ..... Yes ❑ No ❑
Diabetes ..... Yes ❑ No ❑	High Blood Pressure ..... Yes ❑ No ❑	Tuberculosis ..... Yes ❑ No ❑

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 ❑ No ❑	Erythromycin	Yes ❑ No ❑	Dental Anesthetics	Yes ❑ No ❑
Codeine	Yes ❑ No ❑	Penicillin	Yes ❑ No ❑	Jewelry/Metals	Yes ❑ No ❑
Sulfa Drugs	Yes ❑ No ❑	Seafood	Yes ❑ No ❑	Latex	Yes ❑ No ❑

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 _____