MEDICAL HISTORY

Patient Name ***(please print)*** _____

	Yes	No
AIDS	☐	☐
Allergies (Seasonal)	☐	☐
Anemia	☐	☐
Angina (Chest Pain)	☐	☐
Anxiety/Nervousness	☐	☐
Arthritis	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joints	☐	☐
List Joint(s) _____		
Asthma	☐	☐
Blood Disease	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Type _____		
Chemotherapy	☐	☐
Cortisone Medication	☐	☐

	Yes	No
Depression	☐	☐
Diabetes	☐	☐
Dizziness	☐	☐
Drug Addiction	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Excessive Bleeding	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Head Injuries	☐	☐
Heart Conditions	☐	☐
Heart Disease	☐	☐
Heart Lesions (Congenital)	☐	☐
Heart Murmur	☐	☐
Heart Surgery	☐	☐
Hepatitis A	☐	☐

	Yes	No
Hepatitis B	☐	☐
Hepatitis C	☐	☐
High Blood Pressure	☐	☐
HIV Positive	☐	☐
HPV (Human Papilloma Virus)	☐	☐
Jaundice	☐	☐
Jaw Joint Pain	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Pregnant Currently	☐	☐
Radiation (head/neck)	☐	☐
Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐

	Yes	No
Rheumatism	☐	☐
Scarlet Fever	☐	☐
Seizures	☐	☐
Sinus Problems	☐	☐
Sleep Apnea	☐	☐
Stomach Problems	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Tumors	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Other _____		

Special Instructions – Are there any other conditions (ADD, ADHD, Autism, Asperger's, Vision or Hearing Impairment, etc.) that we need to be aware of? If so, please list any special instructions to enable us to give the best care we can. _____

Are you allergic or have you reacted adversely to any of the following medications?

	Yes	No
Aspirin	☐	☐
Darvon	☐	☐
Nitrous Oxide	☐	☐
Percodan	☐	☐

	Yes	No
Latex	☐	☐
Local Anesthetic	☐	☐
Tetracycline	☐	☐
Codeine	☐	☐

	Yes	No
Erythromycin	☐	☐
Valium	☐	☐
Penicillin	☐	☐
Sulfa	☐	☐

Other _____

Are you currently taking or have you ever taken any of the following medications?

	Yes	No
Actonel	☐	☐
Aredia	☐	☐

	Yes	No
Fosamax	☐	☐
Reclast	☐	☐

	Yes	No
Zometa	☐	☐
Boniva	☐	☐

	Yes	No
Blood Thinners	☐	☐

(List) _____

Are you under a physician's care? If so, what for?

_____

What medications are you currently taking?

_____

Family Physician: _____ Phone Number: _____

DENTAL HISTORY

	Yes	No
Sensitivity (hot, cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
Headaches	☐	☐
Earaches	☐	☐
Neck Pain	☐	☐
Jaw Joint Pain	☐	☐
Grinding or clinching teeth	☐	☐
Bleeding, swollen, or irritated gums	☐	☐
Loose, tipped, or shifting teeth	☐	☐
Bad Breath	☐	☐

	Yes	No
Do you have or have you had any of the following?		
- Dentures	☐	☐
- Partial Dentures	☐	☐
- Braces	☐	☐
- Periodontal (gum) treatment	☐	☐
Do you smoke?	☐	☐
How much? _____ For how long? _____		
Do you use chewing tobacco?	☐	☐
How much? _____ For how long? _____		

	Yes	No
If I could change my smile, I would:		
- Replace black metal fillings with tooth colored restorations	☐	☐
- Repair chipped teeth	☐	☐
- Replace missing teeth	☐	☐
- Replace old crowns that don't match	☐	☐

Please share the following dates:
Your last cleaning _____ Your last oral cancer screening _____ Your last complete X-Rays _____

Name of Previous Dentist _____

City _____ State _____ Phone Number _____

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

Consent:

The undersigned herby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough Diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

_____ _____ _____

Patient Signature *(Parent, if child)* Date Dentist Signature