

Name _____

Date _____

MEDICAL HISTORY

Your current health is: () Good () Fair () Poor

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

If yes, please explain: _____

Your Physician's Name: _____

Address: _____

Telephone Number: _____

Please circle YES or NO to indicate if you have had any of the following conditions.

Heart Attack/ Date _____	YES	NO	Diabetes	YES	NO
Heart surgery/Pacemaker	YES	NO	High Cholesterol	YES	NO
Congenital Heart Defect	YES	NO	Asthma	YES	NO
Irregular Heart Beat	YES	NO	Tuberculosis (TB)	YES	NO
Heart Murmur	YES	NO	Sinus Problems	YES	NO
Mitral Valve Prolapse	YES	NO	Difficulty Breathing	YES	NO
Artificial Heart Valves	YES	NO	Emphysema/COPD	YES	NO
High Blood Pressure	YES	NO	HIV/AIDS	YES	NO
Low Blood Pressure	YES	NO	Sexually Transmitted Disease	YES	NO
Rheumatic Fever	YES	NO	Fever Blisters	YES	NO
Circulation Problems	YES	NO	Shingles	YES	NO
Stroke/ Date _____	YES	NO	Chronic Pain	YES	NO
Anemia	YES	NO	Arthritis	YES	NO
Bleeding Problems	YES	NO	Cancer/Type _____	YES	NO
Blood Transfusion	YES	NO	Chemotherapy	YES	NO
Taking Coumadin	YES	NO	Radiation Therapy	YES	NO
Hepatitis/ Type _____	YES	NO	Depression/ Anxiety	YES	NO
Kidney/Liver Disease	YES	NO	Drug/ Alcohol Abuse	YES	NO
Seizure/Fainting/Epilepsy	YES	NO	Glaucoma	YES	NO
Artificial Joints (Knee, Hip, etc.)	YES	NO	Thyroid Disease	YES	NO
Frequent Headaches	YES	NO	Steroid Use	YES	NO

Do you smoke? YES NO How much do you smoke each day? _____

Do you use smokeless tobacco or snuff? YES NO

Please list any other medical conditions you have had that are not listed above:

Have you ever had surgery or a major operation? YES NO

If yes, please list _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU

Please list any medications you are currently taking (please include prescriptions drugs, non-prescription drugs, Aspirin, vitamins or herbs, and Birth Control Pills.)

DRUG NAME

DOSAGE AND HOW OFTEN

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name of pharmacy you use: _____ **Pharmacy phone #:** _____

Are you allergic to any of the following?

Penicillin	YES	NO	Tetracycline	YES	NO
Erythromycin	YES	NO	Sulfa	YES	NO
Aspirin	YES	NO	Codeine	YES	NO
Dental Anesthetics	YES	NO	Latex	YES	NO

Please list any other medications you are allergic to:

DENTAL HISTORY

Date of last dental visit: _____ Date of last dental x-rays: _____

How often do you brush your teeth? _____ How often do you floss? _____

Do your gums bleed when you brush? Yes No Don't Know

Are your teeth sensitive to cold, hot, sweets or pressure? Yes No Don't Know

Have you had any periodontal (gum) treatments? Yes No Don't Know

Have you ever had orthodontic (braces) treatment? Yes No Don't Know

Do you have headaches, earaches or neck pain? Yes No Don't Know

Do you wear removable dental appliances? Yes No Don't Know

Do you like your smile? Yes No Don't Know

Do you clench or grind your teeth while awake or asleep? Yes No Don't Know

Have you had a serious or difficult problem associated with any previous dental treatment? Yes No Don't Know

If so, please explain: _____

Would you describe your current dental health as good? Yes No Don't Know

If not, please explain: _____

FOR WOMEN ONLY:

Are you taking Birth Control Pills? **YES** **NO**

Are you pregnant? **YES** **NO** # of weeks _____

Are you nursing? **YES** **NO**