Name and city of current medical physician: ____________________

Date of last physical examination at your medical doctor's office, approximately: ____________________

Please circle YES or NO

1. Yes No Have you been under the care of a physician in the past 2 years? ____________
2. Yes No Have you had a recent illness or surgery? ____________
3. Yes No Have you ever been hospitalized? ____________
4. Yes No Are you pregnant? ____________

HAVE YOU EVER HAD OR DO YOU HAVE:

5. Yes No Heart trouble or heart surgery? ____________
6. Yes No Pains in the chest or shortness of breath? ____________
7. Yes No High blood pressure or stroke? ____________
8. Yes No Rheumatic fever or heart murmur? ____________
9. Yes No Anemia (low blood) or other blood diseases? ____________
10. Yes No Thyroid trouble? ____________
11. Yes No Jaundice, hepatitis or liver problems? ____________
12. Yes No Diabetes or family history of diabetes? ____________
13. Yes No Any breathing problems (hay fever, asthma, tuberculosis, sinusitis, emphysema)? ____________
14. Yes No Stomach or intestinal problems (ulcers, etc.)? ____________
15. Yes No Kidney or bladder problems? ____________
16. Yes No Cancer or tumors? ____________
17. Yes No Convulsions, seizures, or fainting? ____________
18. Yes No Abnormal or prolonged bleeding? ____________
19. Yes No Syphilis, gonorrhea, social herpes, or AIDS? ____________
20. Yes No Scalp or skin disease? ____________
21. Yes No Arthritis, bone disease, joint problems or replacement? ____________
22. Yes No Eye problems (glaucoma, retinal repair, etc.)? ____________
23. Yes No Use of alcohol, drugs or tobacco? ____________
24. Yes No Sudden weight loss or weight gain? ____________
25. Yes No Lumps in your neck, armpits, or groin? ____________
26. Yes No Recent appearance of discolored areas in your mouth or other parts of your body? ____________
27. Yes No Any other medical condition that we should be aware of? ____________

ARE YOU TAKING NOW OR HAVE YOU TAKEN WITHIN THE LAST 2 YEARS:

28. Yes No Cortisone/Steroids, anti-rejection drugs? ____________
29. Yes No Blood thinners (Coumadin, Warfarin, Heparin)? ____________
30. Yes No Tranquilizers, sedatives, or pain drugs (aspirin)? ____________
31. Yes No Nitroglycerin or other heart medications? ____________
32. Yes No Any other medicine or drugs (including birth control pills)? ____________
33. Yes No Are you currently taking any herbal or natural homeopathic remedies? ____________
    If so, are you under the supervision of an alternative therapist? ____________

HAVE YOU EVER HAD A REACTION OR ALLERGY (LIKE ITCHING, RASH, OR SWELLING) TO:

34. Yes No Local anesthetics (Novocaine, Xylocaine, etc.)? ____________
35. Yes No Penicillin, sulfa drugs or other antibiotics? ____________
36. Yes No Other drugs or medicines? ____________

PLEASE COMPLETE BACK OF THIS PAGE

Last dental visit approximately: ______________________________

What is your immediate dental concern? ______________________________

Please circle YES or NO

1.	Yes	No	Are you presently in any dental pain? ______________
2.	Yes	No	Have you ever had an unfavorable experience in the dental office?______________
3.	Yes	No	Have you ever had orthodontic treatment (braces)? ______________
4.	Yes	No	Have you ever had periodontal (gum) treatment?______________
5.	Yes	No	Do you have any growths or swellings in your mouth? ______________ How long have they existed? ______________
6.	Yes	No	Is any part of your mouth sensitive to temperature extremes, toothbrushing, chewing pressure or sweets?______________
7.	Yes	No	Does food catch between your teeth more than expected?______________
8.	Yes	No	Do you have any pain or soreness in your head and neck area?______________
9.	Yes	No	Are you aware of clenching or grinding your teeth while you're awake or sleeping? ______________
10.	Yes	No	Does your jaw click or pop while eating or yawning? ______________
11.	Yes	No	Do you have frequent headaches?______________
12.	Yes	No	Are you dissatisfied with your teeth and their appearance? ______________
13.	Yes	No	Do you feel you will eventually wear dentures?______________
14.	Yes	No	Do you want to retain your teeth?______________
15.	Yes	No	Do you frequently consume sweets? ______________
16.	Yes	No	Do you snore while sleeping? (not a joke) ______________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health status, or if any of my medications change, I will inform the dentist at the next appointment without fail.

Patient/Legal Guardian signature ______________________ Date ______________

Updated Medical History, Patient signature______________________ Date ______________

Updated Medical History, Patient signature______________________ Date ______________

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DOCTOR'S NOTES