Medical History

Physician's name _____Phone # _____
When was you last physical exam?_____
Are you currently receiving medical care? Yes ___ No ___
If yes please explain _____
Have you had any other serious illnesses, hospitalization or accidents?_____
If yes please explain _____

Please list any Prescription and over the counter drugs, (including vitamins or herbal supplements.) Please also include dosages, and why you are taking them.

_____ _____ _____ _____

_____ _____ _____ _____

For Women;
Are you taking birth control? Yes__ No __ Are you Pregnant? Yes__ No __ Due date _____
Are you nursing? Yes __ No __

Are you allergic to any of the following?

__Asprin	__Penicillin	__Jewelry/metal	Please list any other drugs/materials
__Codine	__Amoxicillin	__Dental anesthetics	_____
__Ibuprofen	__Erythromycin	__Latex	_____
__Vicodin	__Tetracycline	__Sulfa	_____

Have you had any of the following diseases or medical problems?
Please circle yes or no for each item

Y N Anemia	Y N Artificial bones/joints/implants	Y N Heart surgery
Y N Asthma	Y N Artificial Valves	Y N Blood transfusion
Y N Diabetes	Y N Arthritis	Y N Emphysema
Y N Epilepsy/seizure	Y N Congenital heart defect	Y N Fainting spells
Y N Glaucoma	Y N Difficulty breathing	Y N Heart murmur
Y N Ulcers	Y N Fever blisters/Herpes	Y N Heart attack/Stroke
Y N HIV/AIDS	Y N Hemophilia/Abnormal bleeding	Y N Hepatitis__ Type___
Y N Kidney problems	Y N High/Low blood pressure	Y N Mitral Valve Prolapse
Y N Pacemaker	Y N Psychiatric Problems	Y N Radiation Treatment
Y N Venereal disease	Y N Rheumatic/Scarlet fever	Y N Sinus problems
Y N Thyroid problems	Y N Tuberculosis	Y N Osteoporosis
Y N Cancer/chemotherapy-Type_____		Other_____

Dental History;
Have you ever taken bisphosphanate drugs? Like Fosomax, Reclast; _____
Do you require antibiotics before dental treatment? ____ Why?_____
Do you currently have a tooth ache?____
Do your gums bleed? ___
Do you like your smile? _____
Would you like whiter teeth? ___
Have you whitened your teeth in the past? _____When? _____What product? _____
Is your drinking water fluoridated? ___
Have you ever had a serious/difficult problem associated with any previous dental work? ___
Do you now or have you ever experienced pain/discomfort in your jaw joint? ___
Have you been recommended dental work that you haven't had done? ___
How many cans of pop do you drink? _____
Anything else that would be valuable for me to know? _____
Are you currently or have you ever smoked or use tobacco in any form? _____
Have you ever been treated for gum disease? _____
Last dental visit _____ Previous Dentist Name_____

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