

MEDICAL HISTORY**Confidential**

Personal physician: _____ Physician's phone #: _____
 Your current physical health is Good Fair Poor
 Are you taking any prescription / non-prescription / over-the-counter drugs or herbs? No Yes
 Please list each one: _____
 Have you been hospitalized or had a serious illness within the past 5 years? _____

For Women Are you taking birth control pills? No Yes
 Are you pregnant? No Yes Week # _____ Are you nursing? No Yes

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

Alcohol / Drug Abuse	Epilepsy / Seizures	Radiation or Cobalt Treatment
Allergies / Hay Fever	Fainting Spells / Nervousness	Rheumatic Fever
Anemia / Blood Disorders	Heart Surgery / Pacemaker	Heart Murmur
Arthritis	Hemophilia	Shingles / Herpes Virus
Artificial Heart Valve	Abnormal Bleeding	Shortness of Breath
Artificial Joint (Hip, Knee, etc.)	Hepatitis A / Hepatitis B	Sinus Problems
Asthma	High / Low Blood Pressure	Thyroid Disease
Blood Transfusion	HIV Positive	Tuberculosis (TB)
Bruise Easily	Kidney Problems	Lung Disease
Cancer / Chemotherapy	Liver Disease / Jaundice	Ulcers
Congenital Heart Lesion	Migraine Headaches	Venereal Disease
Cortisone Medication	Mitral Valve Prolapse	Used Fen-Phen / Redux
Cosmetic Surgery	Neck / Head Pain	Other _____
Diabetes	Psychiatric Treatment	None of the Above

Cardiovascular Disease (Heart Attack, Angina, Coronary Insufficiency, Coronary Occlusion, Arteriosclerosis
 Stroke, By Pass Surgery, etc.)

Are you Allergic to any of the following drugs? Circle all that apply.

Aspirin	Penicillin	Latex
Codeine	Erythromycin	Other _____
Dental Anesthetics	Tetracycline	None of the above

DENTAL HISTORY

Reason for visit: _____
 How long since your last dental visit? _____ Last cleaning: _____ Last full mouth x-rays: _____
 How often do you brush your teeth? _____ How often do you floss you teeth? _____
 Do you use tobacco in any form? _____ If so, which kind and how much? _____
 Do you use alcoholic beverages (more than two drinks per day)? _____

	Yes/No		Yes/No
Are you apprehensive about dental treatment? _____		Do you have pain in your jaws / head / neck? _____	
Are you aware of grinding or clenching your teeth? _____		Does food stick between your teeth? _____	
Do you have discolored teeth that bother you? _____		Do your gums bleed when brushing / flossing? _____	
Are your teeth sensitive to hot / cold / sweets? _____		Do you have a problem with bad breath? _____	
Have you ever had an unusual reaction to dental treatment? _____			

The information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I authorize the dental staff to perform any necessary dental services that may be needed during diagnosis and treatment.

Signed : _____ Date: _____