

MEDICAL / DENTAL HISTORY

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____

Do you need antibiotic premedication before dental appointments? Yes No

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Do you have any CURRENT HEALTH PROBLEMS? Yes No

Are you under a PHYSICIAN'S CARE now? Yes No

For what? _____

Do you use cigars/cigarettes,
pipe or chewing tobacco? Yes No

What MEDICATIONS are you currently taking? _____

Have you ever taken Fen-Phen/Redux? Yes No

Are you PREGNANT? Yes No

PLEASE CHECK YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	Yes	No		Yes	No		Yes	No
AIDS/HIV Pos.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimers	<input type="checkbox"/>	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (Rheumatism)	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>				Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Abnormal bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	(which type) _____			Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Surgical implant	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco habit	<input type="checkbox"/>	<input type="checkbox"/>
Cough (persistent)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Material allergies	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	(latex, wood, metal, chemicals)					

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

Aspirin Local Anesthetic

Codeine Erythromycin

Penicillin Latex (balloons, gloves, etc.)

Are you aware of being allergic to any other medications or substances? If yes, please list:

Is there any other medical or dental information that you feel I should know? _____

Physician _____
Phone _____
E-mail _____

Reason for today's visit _____ How often do you floss? _____ How often do you brush? _____

Former Dentist _____ Address _____

Date of last dental care _____ Date of last dental x-rays _____

How do you feel about your teeth? _____ Would you like your smile to look better or different? _____

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

_____ FEAR of pain _____ LACK of concern _____ COST of treatment _____ MISSING work time

Check if you have had problems with any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Braces/orthodontics | <input type="checkbox"/> Headaches, earaches or neck pains | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Discolored teeth that bother you | <input type="checkbox"/> Peridontal treatment | <input type="checkbox"/> Sores or growths in your mouth |

I attest to the accuracy of the information on this page. Signature _____ Date _____