MEDICAL HISTORY

Name_____ **Date of Birth**_____

Health problems that you may have, or medications you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Date of last physical_____
Physician's Name and Address:

Y N **Do you use tobacco? Amt.?**_____ **Duration**_____
Y N Do you drink more than 3 alcoholic beverages per day?
Y N Do you use recreational drugs?
Y N Are you taking any medications, pills or drugs? If so what
_____
_____

Y N Are you in good health?
Y N Have you ever had a serious head or neck injury?
Y N Have you ever had a major operation? For?_____
Y N Have you ever been hospitalized? For?_____

Women
Y N Are you taking oral contraceptives?
Y N Are you pregnant or trying to become so?
Y N Are you nursing?

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Latex ☐ Any metals ☐ Dental novocaine ☐ Acrylic ☐ Other_____

Do you have or have you had any of the following? (please circle)

AIDS/HIV	Chest pains	Frequent headaches	Kidney problems	Scarlet fever
Alzheimer's	Cold sores/fever blisters	Genital herpes	Leukemia	Shingles
Anaphylaxis	Congenital heart disorder	Glaucoma	Liver disease	Sickle cell disease
Anemia	Convulsions	Hay fever	Low blood pressure	Sinus trouble
Angina	Cortisone medication	Heart Attack	Lung disease	Spina bifida
Arthritis	**Diabetes**	Heart Disease	Migraine headaches	Stomach/intestinal
Artificial heart valve	Drug addiction	**Heart Murmur**	**Mitral valve prolapse**	Stroke
Artificial joint	Easily winded	**Heart pace maker**	Pain in jaw joints	Swelling of limbs
Asthma	Emphysema	Hemophilia	Parathyroid disease	Thyroid disease
Blood disease	Epilepsy or seizures	Hepatitis A	Psychiatric care	Tonsilitis
Blood transfusion	**Excessive bleeding**	Hepatitis B or C	Radiation treatments	Tuberculosis
Breathing problem	Excessive thirst	**High Blood Pressure**	Recent weight loss	Tumors or growths
Bruise easily	Fainting or dizziness	Hives or rash	Renal dialysis	Ulcers
Cancer	Frequent cough	Hypoglycemia	**Rheumatic fever**	Venereal disease
Chemotherapy	Frequent diarrhea	Irregular heart beat	Rheumatisim	Yellow jaundice
				Other_____

DENTAL HISTORY

Who is your regular dentist?_____
Who referred you to see us?_____
When did you last see a dentist?_____
What was the reason for your visit?_____
How often do you have your teeth cleaned?_____
How frequently do you brush your teeth?_____

How frequently do you floss?_____
Do you use anything else to clean your teeth?
Have family members lost teeth? Y N
Do you clench your teeth? Y N
Have you had previous gum treatment? Y N
Have you had previous braces treatment? Y N

Have you had a complete series of dental x-rays (20 shots) taken within the last 3 years?..... Y..... N.....When?_____

Do you have the following:

☐ Bleeding gums	☐ Clicking jaw	☐ Food catching between teeth	☐ Gum or tooth abscess
☐ Swollen gums	☐ Lip or cheek biting	☐ Bad taste in your mouth	☐ Extractions or missing teeth
☐ Sensitive teeth	☐ Loose teeth	☐ Bad breath	☐ Impacted teeth
☐ Pain in jaw, head or neck	☐ Teeth that have migrated	☐ Difficulty chewing	☐ Plates or dentures
			☐ Dental Implants

Are you interested in:

☐ Replacing missing teeth	☐ **Halitosis (bad breath) treatment**	☐ **Migraine headache treatment**
☐ Whitening your teeth	☐ **Snoring treatment for yourself**	☐ Straightening your teeth
☐ **Dental implant treatment**	☐ **Snoring treatment for your significant other**	☐ None of the above

Authorization and release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered to my satisfaction. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor_____ Today's Date_____