Today's Date: ____/______/_____

Medical History

(ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTAIL)

Patient's Name____ Birth Date___________________

Name of Primary Physician______________________________ Physician's Phone ( ) ________________

Patient Information:

Are you presently under a Doctor's care: Yes / No Explain:__________________________

Have you been hospitalized in the past 5 years? Yes / No Explain: _________________________

Do you use tobacco products? Chew or Smoke? Yes / No Which? ___________ How much? _____

Have you participated in an alcohol or drug rehab program? Yes / No Explain: __________________________

Women: *Please check*

[ ] Pregnant [ ] Nursing [ ] Taking Birth Control Pills [ ] Reached Menopause

Do you or have you ever had any of the following:

Artificial Heart Valve	Yes/No	Blood Thinner	Yes/No	EPI Sensitivity	Yes/No	Pre-Med Amox	Yes/No
Pre-Med Clind	Yes/No	Pre-Med Other	Yes/No	Arthritis	Yes/No	Artificial Joints	Yes/No
Asthma	Yes/No	Breathing Problems	Yes/No	Cancer	Yes/No	Cold Sores	Yes/No
Cong. Heart Defect	Yes/No	Congest heart fail	Yes/No	Diabetes	Yes/No	Dizziness	Yes/No
Epilepsy	Yes/No	Excessive Bleeding	Yes/No	Fainting	Yes/No	Glaucoma	Yes/No
Head injuries	Yes/No	Heart Disease	Yes/No	Heart Murmur	Yes/No	Hepatitis A	Yes/No
Hepatitis B	Yes/No	Hepatitis C	Yes/No	Herpes	Yes/No	High Blood Pressure	Yes/No
HIV	Yes/No	Jaundice	Yes/No	Kidney Disease	Yes/No	Leukemia/Lymphoma	Yes/No
Liver Disease	Yes/No	Memory Issues	Yes/No	Mental Disorders	Yes/No	Other	Yes/No
Pacemaker	Yes/No	Parkinson's Disease	Yes/No	Radiation	Yes/No	Rheumatic Fever	Yes/No
Shortness of breath	Yes/No	Sinus Problems	Yes/No	Stomach Problems	Yes/No	Stroke	Yes/No
Thyroid Problems	Yes/No	Tuberculosis	Yes/No	Ulcers	Yes/No	Venereal Disease	Yes/No

If you answered yes, explain & give year / any additional medical history: _________________________________

____

____

____

Check beside any allergies:

[ ] Codeine [ ] Penicillin [ ] Erythromycin [ ] Sulfa [ ] Aspirin [ ] Iodine

[ ] Latex [ ] Nuts [ ] Other: ____

Please list current medications:

____

____

____

PLEASE COMPLETE OTHER SIDE

Do have any of the following:

Heart Bypass Yes / No Date: __________ Stents Yes / No Date: __________

Donor Organs Yes / No Date: __________

Do you take bisphosphonates drugs for your bone health?
(Such as Boniva, Fosamax, Actonel, etc.) Yes / No

Have you ever had a reaction to any dental anesthetics? Yes / No

If you answered yes, please give us further information: ____

____

____

DENTAL HISTORY

Please Circle

1. Yes No Do you Floss? How many times per week? _____
2. Yes No Do your gums bleed when you brush or floss?
3. Yes No Does food get stuck between your teeth?
4. Yes No Do you have frequent headaches when you get up in the morning?
5. Yes No Have you ever had orthodontic (braces) treatment?
6. Yes No Do you feel that you will eventually have to wear dentures?
7. Yes No Do you get frustrated because you always have something to be treated when you visit the dentist?
8. Yes No Would you be interested in restoring your teeth with materials that will last many years before needing to be replaced?
9. How long has it been since your last dental check-up? [ ] less than 1 year [ ] 1-2 years [ ] Over 2 years
10. What is the date of your last full mouth x-rays (Panoramic or 16 small films)?______________________________________
11. Why did you leave your last dentist?____
12. Which of the following causes you the most concern about your dental care? ***Please circle one***

Cost of treatment you need **Time spent in the office** **Pain during treatment**

I certify that the answers provided are correct to the best of my knowledge. If I have any changes in my health status or medications, I will inform the dentist or staff at my next appointment.

X____

Patient signature (Parent or Guardian)

NOTES:

Reviewed by: _____________________