Last Name: _____First Name: _____Middle Initial_____

Medical History

What is your estimation of your general health? ☐ Good ☐ Fair ☐ Poor

☐ Yes ☐ No Are you currently under the regular care of a physician? If yes, for what?

_____

☐ Yes ☐ No Do you smoke? If yes, for how long? _____ How much? _____

Have you ever had or do you now have any of the conditions listed below? Please check the appropriate box.

Yes	No		Yes	No		Yes	No	
☐	☐	Allergies	☐	☐	Hay Fever	☐	☐	Asthma
☐	☐	Sinus Problems	☐	☐	Respiratory Problems	☐	☐	Arthritis
☐	☐	Prosthetic Joints	☐	☐	Blood Disease	☐	☐	Anemia
☐	☐	Excessive Bleeding	☐	☐	Easy Bruising	☐	☐	Stroke
☐	☐	Heart Disease	☐	☐	Heart Murmur	☐	☐	Heart Attack
☐	☐	Pain/Pressure in Chest	☐	☐	Shortness of Breath	☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure	☐	☐	Prosthetic Valves	☐	☐	Pacemaker
☐	☐	Cancer	☐	☐	Tumors	☐	☐	Radiation Treatment
☐	☐	Chemotherapy Treatment	☐	☐	Diabetes	☐	☐	Thyroid Disease
☐	☐	Leukemia	☐	☐	Nervous Disorders	☐	☐	Epilepsy, Fits
☐	☐	Fainting	☐	☐	Glaucoma	☐	☐	Head Injuries
☐	☐	Dizziness	☐	☐	Mental Disorders	☐	☐	Liver Disease
☐	☐	Hepatitis	☐	☐	Jaundice	☐	☐	Stomach Problems
☐	☐	Ulcers	☐	☐	Kidney Disease	☐	☐	Immune Disorder
☐	☐	Tuberculosis	☐	☐	Scarlet Fever	☐	☐	Rheumatic Fever
☐	☐	Rheumatism	☐	☐	Venereal Disease	☐	☐	HIV Infection, AIDS

If any of the conditions above is marked “yes”, please explain.

_____

If you have any other condition you feel we should be aware of, please indicate here.

_____

Medications:

Please list all medications or drugs (prescription and over-the-counter) you are taking.

Have you ever had a reaction to any of the following substances? Please check the appropriate box.

Yes	No		Yes	No	
☐	☐	Penicillin	☐	☐	Sulfa Drugs
☐	☐	Codeine	☐	☐	Asprin
☐	☐	Sleeping Pills (Valium, Halcion, …	☐	☐	Tetracycline/Coxycycline
☐	☐	Dental anesthetic	☐	☐	Ibuprofen
☐	☐	Clindamycin	☐	☐	Vicodin
☐	☐	Latex	☐	☐	Other_____

Physician_____Phone_____

Address_____City_____

Date of Last Physical_____

Last Name: First Name: Middle Initial

Dental History

What is your chief complaint today?

Please check the appropriate box below.

Yes	No	
☐	☐	Do your teeth bother you?
☐	☐	Do you have any jaw pain and/or numbness?
☐	☐	Do you have any problems chewing?
☐	☐	Do you gag easily?
☐	☐	Do you suffer from dry mouth or a lack of saliva?
☐	☐	Have you had any serious trouble associated with any previous dental treatment?
☐	☐	Do you have bleeding gums?
☐	☐	Have you ever had periodontal (gum) treatment?

If you answered yes to any of the above questions, please explain.

General Dentist_____ City_____

How long have you been seeing him/her?_____

Who may we thank for referring you?_____

For Women:

Are you Pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control medication? ☐ Yes ☐ No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. **I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will immediately notify the doctor of any change in my health or medication.**

_____ Relation to Patient

Patient/Parent/Guardian Name (please print)

_____ _____

Signature Date

We look forward to meeting you.

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