YOUR MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone _____ Date of last visit _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:

_____

_____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one:

_____

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

Please check below if you have ever had any of the following diseases or medical problems:

☐ Abnormal Bleeding
☐ Alcohol/Drug Abuse
☐ Anemia
☐ Arthritis
☐ Artificial Bones/Joints/Valves
☐ Asthma
☐ Blood Transfusion
☐ Cancer/Chemotherapy
☐ Colitis
☐ Congenital Heart Defect
☐ Diabetes
☐ Difficulty Breathing
☐ Emphysema
☐ Epilepsy
☐ Fainting Spells
☐ Frequent Headaches
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack
☐ Heart Murmur
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis
☐ Herpes/Fever Blisters
☐ High Blood Pressure
☐ HIV/AIDS
☐ Hospitalized for Any Reason
☐ Kidney Problems
☐ Liver Disease
☐ Low Blood Pressure
☐ Lupus
☐ Mitral Valve Prolapse
☐ Osteoporosis/Paget's Disease
☐ Pacemaker
☐ Psychiatric Problems
☐ Radiation Treatment
☐ Rheumatic/Scarlet Fever
☐ Seizures
☐ Shingles
☐ Sickle Cell Disease/Traits
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Ulcers
☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

_____

Are you allergic to any of the following?

☐ Aspirin
☐ Codeine
☐ Dental Anesthetics
☐ Erythromycin
☐ Tetracycline
☐ Latex
☐ Penicillin
☐ Other

Please list any other drugs/materials that you are allergic to:

_____

_____

_____

For Women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Week #_____

Are you nursing? ☐ Yes ☐ No

YOUR DENTAL HISTORY

Why have you come to the dentist today?_____

_____

How long since your last dental visit? _____

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? ☐ Yes ☐ No

Please specify _____

Have you lost any teeth? ☐ Yes ☐ No

If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

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