Today's Date: ____/_____/_____

Medical History

(ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTAIL)

Patient's Name _____ Birth Date _____

Patient Information:

Are you presently under a doctor's care other than routine: Yes / No Explain: _____

Have you been hospitalized or had a major operation? Yes / No Explain: _____

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

Women: *Please check*

☐ Pregnant (Due Date: _____) ☐ Nursing ☐ Taking Birth Control Pills

All: Please check if you have ever had any of the following and explain below:

Pre-Med Amoxicillin	☐	Chemotherapy	☐	Heart Disease	☐	Parkinson's Disease	☐
Pre-Med Clindamycin	☐	Cold Sores	☐	Heart Murmur	☐	Psychiatric Care	☐
Pre-Med Other	☐	Congenital Heart Defect	☐	Hepatitis A	☐	Radiation	☐
AIDS/HIV Positive	☐	Congestive Heart Failure	☐	Hepatitis B	☐	Rheumatic Fever	☐
Alzheimer's/Dementia	☐	Depression	☐	Hepatitis C	☐	Schizophrenia	☐
Anxiety	☐	Diabetes	☐	High Blood Pressure	☐	Shortness of Breath	☐
Arthritis	☐	Dizziness	☐	High Cholesterol	☐	Sinus Problems	☐
Artificial Heart Valve	☐	Epilepsy	☐	Hypoglycemia	☐	Stomach Problems	☐
Artificial Joints	☐	EPI Sensitivity	☐	Jaundice	☐	Stroke	☐
Asthma	☐	Excessive Bleeding	☐	Kidney Disease	☐	Thyroid Problems	☐
Bipolar Disorder	☐	Fainting	☐	Leukemia/Lymphoma	☐	Tuberculosis	☐
Blood Thinner	☐	Glaucoma	☐	Liver Disease	☐	Ulcers	☐
Breathing Problems	☐	Head Injuries	☐	Osteoporosis	☐		
Cancer	☐	Heart Attack	☐	Pacemaker	☐		

Please list additional serious illnesses, or if you answered "yes" to any illnesses/health conditions above, please elaborate:

_____

_____

_____

Are you allergic to any of the following:

☐ Codeine ☐ Penicillin ☐ Erythromycin ☐ Sulfa ☐ Aspirin ☐ Local anesthetics

☐ Latex ☐ Nuts ☐ Other: _____

Please list any current medications, pills, drugs, herbal supplements/remedies, or regular doses of aspirin:

_____

_____

_____

PLEASE COMPLETE OTHER SIDE

DENTAL HISTORY

Yes No Do you Floss? How many times per week? _____

Yes No Do your gums bleed when you brush or floss?

Yes No Does food get stuck between your teeth?

Yes No Do you have frequent headaches when you get up in the morning?

Yes No Have you ever had orthodontic (braces) treatment? If within the past 2 years, where? _____

Yes No Do you get frustrated because you always have something to be treated when you visit the dentist?

Yes No Are you interested in whitening your teeth?

Yes No Are you interested in straightening your teeth?

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**

How long has it been since your last dental check-up? ☐ less than 1 year ☐ 1-2 years ☐ Over 2 years

What is the date of your last full mouth x-rays (Panoramic or 16 small films)? _____

Why did you leave your last dentist? _____

Name & contact information of your last dentist (phone/email): _____

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: _____