Today's Date: ____/_____/_____

Medical History

(ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTAIL)

Patient's Name_____ Birth Date_____

Name of Primary Physician_____ 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 Smoking? 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 [ ] Reach Menopause

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

Heart Attack	Yes / No	High Blood Pressure	Yes / No	Asthma	Yes / No
Stroke	Yes / No	Low Blood Pressure	Yes / No	Leukemia	Yes / No
Artificial joint	Yes / No	Hepatitis or Jaundice	Yes / No	Epilepsy	Yes / No
Seizures	Yes / No	Congenital heart disorder	Yes / No	Rheumatic Fever	Yes / No
Stroke	Yes / No	Head / Neck Radiation	Yes / No	Scarlet Fever	Yes / No
Diabetes	Yes / No	Fainting/Dizziness	Yes / No	Chronic Sinusitis	Yes / No
Arthritis	Yes / No	Stomach Ulcers	Yes / No	Respiratory Disease	Yes / No
Tinnitus	Yes / No	Cancer	Yes / No	Hepatitis A	Yes / No
Lupus	Yes / No	Chemotherapy	Yes / No	Hepatitis B or C	Yes / No
Convulsions	Yes / No	Radiation treatment	Yes / No	Depression	Yes / No
Thyroid problems	Yes / No	Alzheimer's disease	Yes / No	Genital herpes	Yes / No
Emphysema	Yes / No	HIV positive/ AIDS	Yes / No	Noises in Jaw Joint	Yes / No
Tuberculosis	Yes / No	Venereal disease	Yes / No	Clenching / Grinding	Yes / No

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

_____

_____

_____

Check beside any medications you are allergic to:

[ ] Local anesthetic [ ] Codeine [ ] Penicillin [ ] Erythromycin

[ ] Iodine [ ] Aspirin [ ] Sulfa drugs [ ] Other: _____

Please list current medications:

_____

_____

PLEASE COMPLETE OTHER SIDE

Do have any of the following:

Artificial Heart Valves	Yes / No Date: _____	Heart Bypass	Yes / No Date: _____
Joint Replacement	Yes / No Date: _____	Pacemaker	Yes / No Date: _____
Stents	Yes / No Date: _____	Donor Organs	Yes / No Date: _____
Congenital Heart Defects	Yes / No	HIV / AIDS	Yes / No

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

Have you ever had a reaction to latex gloves? 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: _____