Patient Name: _____ **Date of Birth:** ____ / ____ / ____

MEDICAL HISTORY

Have you had, or been diagnosed with any of the following? Please check all those that apply:

- □ AIDS
- □ Allergies:
  - □ Latex
  - □ Penicillin
  - □ Other: _____
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Blood Disease
- □ Cancer: _____
- □ Diabetes: _____
- □ Dizziness
- □ Epilepsy
- □ Excessive Bleeding
- □ Fainting
- □ Glaucoma
- □ Growths
- □ Hay Fever
- □ Head Injury
- □ Heart Disease
- □ Heart Murmur
- □ Heart Valve Replace.
- □ Hepatitis: _____
- □ High Blood Pressure
- □ Jaundice
- □ Joint Replacement
- □ Kidney Disease
- □ Liver Disease
- □ Mental Disorder
- □ Mitral Valve Prolapse
- □ Multiple Sclerosis
- □ Nervous Disorders
- □ Pacemaker
- □ Are you Pregnant?
  Due Date: _____
- □ Radiation Treatment
- □ Respiratory Problem
- □ Rheumatism
- □ Sinus Problems
- □ Stomach Problems
- □ Stent
- □ Stroke
- □ Tuberculosis
- □ Tumor
- □ Ulcers
- □ Venereal Disease
- □ Other: _____

Are you currently taking Blood Thinner Medication: Y N

Have you ever taken medication for Osteoporosis (ie: Fosomax, Aredia, Zometa, Actonal, Boniva, etc.) Y N

Please list all medications you are currently taking. Please include the dosage:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Have you ever been told you need to be pre-medicated prior to dental treatment? Y N
If Yes, for what reason? _____

Have you ever had any complications following dental treatment? Y N
If Yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two (2) years? Y N
If Yes, please explain: _____

Are you currently under the care of a physician? Y N If Yes, please explain: _____
Name of Physician: _____ **Phone #:** _____

Do you have any health problems that need further clarification? Y N
If Yes, please explain: _____
_____

DENTAL HISTORY

Date of last Dental Visit: _____ **Reason for the Visit:** _____
Were x-rays taken at that visit? Y N **Type of x-rays, if known:** _____
How many times a day do you brush you teeth? _____
Do you floss your teeth? Y N **If Yes, how frequently?** _____
Have you ever been told you have periodontal (gum) disease? Y N
Have you ever received treatment for gum disease? Y N **If Yes, how long ago?** _____
Do you grind or clench your teeth? Y N
Do you smoke? Y N
Do you chew tobacco? Y N
Do your jaws "pop" or "click"? Y N
Do you have frequent headaches? Y N
Have you ever had orthodontic treatment (braces)? Y N **If Yes, how long ago?** _____
Are you happy with the appearance of your smile? Y N
If No, what would you change about it? _____

To the best of my knowledge, all of the preceding answers and information regarding my health are true and accurate. If I ever have a change in my medical history, or any medications I am taking, I will inform the doctors at my next dental appointment, without fail.

_____ _____
Signature of Patient, Parent or Legal Guardian **Date**