

MEDICAL HISTORY

Print Name: _____

Your answers to the following are for our records only and are confidential.

Are you currently under a physician's care? Yes No

If yes, please explain: _____

Please list all medications you are currently taking including vitamins, natural products or herbal supplements.

Please list: _____

Please circle any of the following which you have at present or had in the past:

Latex/metal sensitivity	Yes	Allergies/Hives	Yes	Cancer	Yes
Artificial heart valves	Yes	Asthma	Yes	Diabetes	Yes
Heart murmurs	Yes	Arthritis/Rheumatism	Yes	Stroke	Yes
AIDS/HIV	Yes	Rheumatic fever	Yes	Chemotherapy	Yes
Pacemaker	Yes	Liver disease	Yes	Radiation treatment	Yes
Epilepsy/Seizure	Yes	Psychiatric problems	Yes	Blood disorder	Yes
Heart disease	Yes	Tuberculosis	Yes	Kidney problems	Yes
Hepatitis	Yes	Emphysema	Yes	Smoke/forms of tobacco	Yes
Implant prosthesis	Yes	Ulcers	Yes	Artificial joints/prosthesis	Yes
Bleed excessively	Yes	Venereal disease	Yes	Fainting/Dizzy Spells	Yes
Drug addiction	Yes	Anemia/Hemophilia	Yes	Take Birth Control	Yes
Sleep apnea	Yes	Thyroid disease	Yes	Could you be pregnant	Yes
Wear a C-pap	Yes	High blood pressure	Yes	If Yes, Due Date:	_____

Have you had an allergic reaction to any antibiotics, medications, substances or food? Yes No

Other: _____

Have you ever taken any form of the prescription bisphosphonate(for bone loss)? Yes No

DENTAL HISTORY

Purpose of initial visit: _____

Date of last cleaning: _____

Previous dentist name: _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Are you happy with the appearance of your teeth? Yes No

Have any teeth been removed? Yes No

Have any teeth been replaced? Yes No

Are you interested in permanent replacement? Yes No

Have you had soreness around your face or ear? Yes No

Do you feel your breath is unpleasant at times? Yes No

Does food get caught in your teeth? Yes No

Do you have a fear of dentists? Yes No

Were x-rays taken? Yes No

Have you had orthodontic work? Yes No

Does your jaw click or pop? Yes No

Do you grind your teeth? Yes No

Have you had gum surgery? Yes No

Do your gums bleed or hurt? Yes No

If Yes, when? _____

Are your teeth sensitive to:

Hot Cold Sweets Pressure None

Have you had complications with dental treatment in the past? Yes No

If yes, please explain. _____

Do you have any questions or concerns? _____

Signature of Patient _____

Date _____