

**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: \_\_\_\_\_

Do you currently take any medications, vitamins, natural products or herbal supplements?  **Yes**  **No**

If yes, please list: \_\_\_\_\_

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

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

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

**Other:** \_\_\_\_\_

**DENTAL HISTORY**

Purpose of initial visit: \_\_\_\_\_ Do you have a fear of dentists?  **Yes**  **No**

Date of last cleaning: \_\_\_\_\_ Were x-rays taken?  **Yes**  **No**

Previous dentist name: \_\_\_\_\_ Have you had orthodontic work?  **Yes**  **No**

How often do you BRUSH your teeth? \_\_\_\_\_

How often do you FLOSS your teeth? \_\_\_\_\_ Does your jaw click or pop?  **Yes**  **No**

Are you happy with the appearance of your teeth?  **Yes**  **No** Have you had orthodontic work?  **Yes**  **No**

Have any teeth been removed?  **Yes**  **No** Do you grind your teeth?  **Yes**  **No**

Have any teeth been replaced?  **Yes**  **No** Do your gums bleed or hurt?  **Yes**  **No**

Are you interested in permanent replacement?  **Yes**  **No** If Yes, when did your gums bleed or hurt? \_\_\_\_\_

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

Do you feel your breath is unpleasant at times?  **Yes**  **No** Are your teeth sensitive to.... (circle all that apply)

Does food get caught in your teeth?  **Yes**  **No** **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?** \_\_\_\_\_