

# MEDICAL HISTORY

Do you have a personal Physician?  Yes  No

Physician's Name:

Physician's phone number: ( )

Date of last visit:

Your current health is:  Good  Fair  Poor

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

Please explain:

Are you taking any prescription or over-the-counter drugs?  Yes  No

If so, please list each one:

Please check the box of any of the following drugs to which you are allergic:

Penicillin  Tetracycline  Latex  Aspirin  
 Codeine  Erythromycin  Dental Anesthetics  Other

Please list any other Drug You Are Allergic To:

# DENTAL HISTORY

Why have you come to the dentist's today?

Are you currently in pain?  Yes  No Have you ever had a serious or difficult problem with any dental work?  Yes  No

Do you now, or have you ever, experienced any pain / discomfort in your jaw joint (TMJ/TMD)  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No Do your gums ever bleed?  Yes  No

How many times a day do you brush? How many times a day do you floss?

Type of brush bristles?  Hard  Soft  Medium

## I understand...

that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Your Signature:

Date Signed:

## Thank you, and welcome:

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the Center for Disease Control, the American Dental Association, and our own careful management and attention to detail and the welfare of our patients.

Please Circle Y-Yes or N-No as it pertains to your medical history:

Y N Heart Attack/Stroke	Y N Cancer/Chemotherapy
Y N Seizures/Fainting Spells	Y N Heart Murmur
Y N Diabetes/Tuberculosis	Y N Rheumatic Fever
Y N Drug/Alcohol Abuse	Y N HIV+/AIDS
Y N Venereal Disease	Y N Heart Surgery/Pacemaker
Y N Shingles	Y N Hemophilia/Abnormal Bleeding
Y N Ulcers/Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Kidney Problems
Y N Anemia/Radiation Treatment	Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis	Y N Blood Transfusions
Y N Difficulty Breathing	Y N Sinus Problems
Y N High/Low Blood Pressure	Y N Hospitalization for any reason
Y N Hepatitis	Y N Severe/Frequent Headaches
Y N Emphysema/Glaucoma	Y N Smoker

Please list any other serious medical conditions that you have ever had:

**For Women:** Are you taking birth control pills?  Yes  No

Are you nursing?  Yes  No Are you pregnant?  Yes  No

Week # \_\_\_\_\_