Patient Name: **Birth Date:** **Current Date:**

Medical History

Medical History

For New Patients: When is the last time you visited a dentist?

For New Patients: Who was your previous dentist?

For New Patients: Does your former dentist have any records or x-rays that need to be transferred here?

Are you having problems now? ◯ Yes ◯ No

If Yes:

Is your present dental health good? ◯ Yes ◯ No

Do you wear dentures? ◯ No ◯ Yes - Partial ◯ Yes - Full

If you wear dentures, are you unhappy with them? ◯ Yes ◯ No ◯ N/A

If you wear dentures, are you interested in permanent replacement options? ◯ Yes ◯ No ◯ N/A

Are you apprehensive about dental treatment? ◯ Yes ◯ No

Have you had any adverse reactions to local anesthetic? ◯ Yes ◯ No

If Yes, please explain:

Have you had any periodontal (gum) treatments? ◯ Yes ◯ No

Do your gums bleed or feel tender or irritated? ◯ Yes ◯ No

Are your teeth sensitive to hot, cold, or pressure? ◯ Yes ◯ No

Are you unhappy with the appearance of your teeth? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

If Yes, please explain

Are you aware of grinding or clenching your teeth? ◯ Yes ◯ No

Do you have headaches, ear aches, or neck pains? ◯ Yes ◯ No

Have you worn braces on your teeth (orthodontics)? ◯ Yes ◯ No

Do you have discolored teeth that bother you? ◯ Yes ◯ No

Would you like your smile to look better or different? ◯ Yes ◯ No

Do you have any current health problems? ◯ Yes ◯ No

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

If Yes:

Have you ever been hospitalized? ◯ Yes ◯ No

Have you ever had major surgery? ◯ Yes ◯ No

If Yes:

Are you currently taking any medications? ◯ Yes ◯ No

If Yes, please list below:

Have you ever taken Fen-Phen/Redux? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

If Yes, please explain:

Are you pregnant? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Are you allergic to or have you reacted adversely to any of the following medications? ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Latex Gloves ☐ Nitrous Oxide ☐ Erythromycin ☐ Local Anesthetic

Are you aware of being allergic to any other medications or substances? ◯ Yes ◯ No

If Yes, please list below:

Is there any other Medical or Dental information that you feel we should know about?

Family Physician:

Physician Phone:

Please mark Yes or NO for each of the following which you have had or currently have:

AIDS/HIV positive: ◯ Yes ◯ No

Alzheimers Disease: ◯ Yes ◯ No

Anaphylaxis: ◯ Yes ◯ No

Angina: ◯ Yes ◯ No

Arthritis: ◯ Yes ◯ No

Artificial Joint: ◯ Yes ◯ No

Artificial Heart Valve: ◯ Yes ◯ No

Asthma: ◯ Yes ◯ No

Blood Disease: ◯ Yes ◯ No

Breathing Problems: ◯ Yes ◯ No

Bruise Easily: ◯ Yes ◯ No

Cancer: ◯ Yes ◯ No

Chemotherapy: ◯ Yes ◯ No

Chest Pains: ◯ Yes ◯ No

Cold Sores/Fever Blisters: ◯ Yes ◯ No

Congenital Heart Disorder: ◯ Yes ◯ No

Convulsions: ◯ Yes ◯ No

Diabetes: ◯ Yes ◯ No

Drug Addiction: ◯ Yes ◯ No

Emphysema: ◯ Yes ◯ No

Epilepsy or Seizures: ◯ Yes ◯ No

Excessive Bleeding: ◯ Yes ◯ No

Excessive Thirst: ◯ Yes ◯ No

Fainting Spells/Dizziness: ◯ Yes ◯ No

Frequent Cough: ◯ Yes ◯ No

Frequent Headaches: ◯ Yes ◯ No

Glaucoma: ◯ Yes ◯ No

Heart Attack/Failure: ◯ Yes ◯ No

Heart Murmur: ◯ Yes ◯ No

Heart Pacemaker: ◯ Yes ◯ No

Heart Trouble/Disease: ◯ Yes ◯ No

Please mark Yes or NO for each of the following which you have had or currently have:

Hemophilia: ◯ Yes ◯ No

Hepatitis A:

	◯ Yes ◯ No
Hepatitis B or C:	◯ Yes ◯ No
High Blood Pressure:	◯ Yes ◯ No
Hives or Rash:	◯ Yes ◯ No
Hypoglycemia:	◯ Yes ◯ No
Irregular Heartbeat:	◯ Yes ◯ No
Kidney Problems:	◯ Yes ◯ No
Leukemia:	◯ Yes ◯ No
Liver Disease:	◯ Yes ◯ No
Low Blood Pressure:	◯ Yes ◯ No
Lung Disease:	◯ Yes ◯ No
Mitral Valve Prolapse:	◯ Yes ◯ No
Pain in Jaw Joints:	◯ Yes ◯ No
Parathyroid Disease:	◯ Yes ◯ No
Psychiatric Care:	◯ Yes ◯ No
Radiation Treatments:	◯ Yes ◯ No
Recent Weight Loss:	◯ Yes ◯ No
Renal Dialysis:	◯ Yes ◯ No
Rheumatic Fever:	◯ Yes ◯ No
Rheumatism:	◯ Yes ◯ No
Shingles:	◯ Yes ◯ No
Sickle Cell Disease:	◯ Yes ◯ No
Sinus Trouble:	◯ Yes ◯ No
Spina Bifida:	◯ Yes ◯ No
Stomach Disease:	◯ Yes ◯ No
Stroke:	◯ Yes ◯ No
Swelling of Limbs:	◯ Yes ◯ No
Thyroid Disease:	◯ Yes ◯ No
Tonsillitis:	◯ Yes ◯ No
Tuberculosis:	◯ Yes ◯ No
Tumors or Growths:	◯ Yes ◯ No
Yellow Jaundice:	◯ Yes ◯ No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature **Date**