MEDICAL HISTORY

Date ______ Name (Last, First, M.I) ______ Preferred Name

Name and phone number of Physician ______

Are you taking any medication now? ☐ Yes ☐ No For what purpose? ______

Please list Prescriptions or Over-the-Counter Medications, Herbal supplements (including fluoride): ______

______

______

Do you require premedication for dental procedures? ☐ Yes ☐ No Reason? ______

Are you allergic (i.e. itching, rash) or made sick by *penicillin*, *aspirin*, *codeine*, *local anesthetic*, or *latex*? ☐ Yes ☐ No

Please list any and all allergies: ______

Have You Ever Been Treated For:

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Ulcers	☐	☐	Infective Endocarditis	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐	Epilepsy	☐	☐
Anemia	☐	☐	Herpes (Cold Sores)	☐	☐	Sinus Trouble	☐	☐
STDs	☐	☐	Asthma or Hay Fever	☐	☐	Hepatitis	☐	☐
AIDS/HIV	☐	☐	Pacemaker	☐	☐	Valvulitis (transplant)	☐	☐
Arthritis	☐	☐	Stroke	☐	☐	Drug Addiction	☐	☐
Cancer	☐	☐	Cardiac Transplant	☐	☐	Joint Replacement	☐	☐
Tuberculosis	☐	☐	Artificial Heart Valve	☐	☐	Congenital Heart Condition	☐	☐
Lung Disease	☐	☐	Jaundice	☐	☐	Autism/Aspergers	☐	☐

Do you have any disease, condition or problem not listed? Please List ______

Are you subjects to prolonged bleeding? ☐ Yes ☐ No

Have you ever taken Fosamax, Actonel or Bisphosphonates? ☐ Yes ☐ No

Women*:* Are you pregnant or is there a possibility you may be? ☐ Yes ☐ No Due Date: ______

Do you take birth control pills? ☐ Yes ☐ No

Do you anticipate becoming pregnant? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

______ Patient Signature

______ Staff Signature

Turn over →

Dental History

Reason for visit? ____

____

When was your last dental visit? ______________ What was done at that visit? ______________________

When was your last dental cleaning? __________ X-rays? __________ Previous Dentist________________

Have you ever had any serious problem with previous dental treatment?

____

How often do you brush? ______________ Floss? ______________________

	Yes	No	Don't know	
Do you have Fluoride in your water?	☐	☐	☐	
Do your gums bleed while brushing or flossing?	☐	☐		
Are your teeth sensitive to cold or hot or sweets?	☐	☐		Please explain________________
Do you clench or grind your jaws?	☐	☐	☐	
Do you smoke or use tobacco?	☐	☐		How often? ________________
Are you happy with your smile?	☐	☐		

If No, Please explain ____

____

Please add anything you feel is important: ______________________________

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