



# MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Your current physical health is: **Good Fair Poor**

Are you currently under the care of a physician? Yes No

Please Explain: \_\_\_\_\_

Do you smoke or use tobacco in any form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any medications? Yes No

Please list each one: \_\_\_\_\_

Have you ever had any of the following diseases or medical problems?

- |                                    |                                 |
|------------------------------------|---------------------------------|
| Y N Abnormal Bleeding              | Y N Hepatitis                   |
| Y N Alcohol / Drug Abuse           | Y N Herpes / Fever Blisters     |
| Y N Anemia                         | Y N High Blood Pressure         |
| Y N Arthritis                      | Y N Hospitalized for any reason |
| Y N Artificial Bones/Joints/Valves | Y N Kidney Problems             |
| Y N Asthma                         | Y N Liver Disease               |
| Y N Blood Transfusion              | Y N Low Blood Pressure          |
| Y N Cancer/ Chemotherapy           | Y N Mitral Valve Prolapse       |
| Y N Colitis                        | Y N Pacemaker                   |
| Y N Congenital Heart Defect        | Y N Psychiatric Problems        |
| Y N Diabetes                       | Y N Radiation Treatment         |
| Y N Difficulty Breathing           | Y N Rheumatic / Scarlet Fever   |
| Y N Emphysema                      | Y N Seizures                    |
| Y N Epilepsy                       | Y N Shingles                    |
| Y N Fainting Spells                | Y N Sickle Cell Disease / Trait |
| Y N Frequent Headaches             | Y N Sinus Problems              |
| Y N Glaucoma                       | Y N Stroke                      |
| Y N Hay Fever                      | Y N Thyroid Problems            |
| Y N Heart Attack / Surgery         | Y N Tuberculosis (TB)           |
| Y N Heart Murmur                   | Y N Ulcers                      |
| Y N Hemophilia                     | Y N Venereal Disease            |

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

Are you allergic to any of the following?

- |                        |                      |                  |
|------------------------|----------------------|------------------|
| Y N Aspirin            | Y N Erythromycin     | Y N Penicillin   |
| Y N Codeine            | Y N Jewelry / Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex            | Y N Other        |

Please list any other drugs / materials that you are allergic to: \_\_\_\_\_

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

Are you pregnant? Yes No Week #: \_\_\_\_\_

Are you nursing? Yes No

# DENTAL HISTORY

Why have you come to the dentist today? \_\_\_\_\_

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

If so, when: \_\_\_\_\_

Do you require Anitbiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem with any previous dental work? Yes No

Have you ever had gum treatment? Yes No

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

Any unfavorable dental experiences? Yes No

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

Your current dental health is: Good Fair Poor

Do you like your smile? Y N Do your gums bleed? Y N

How many times do you: floss/week? \_\_\_\_\_ brush/day? \_\_\_\_\_

Are your teeth sensitive to heat, cold or anything else? \_\_\_\_\_

Have you lost any teeth? Y N If so, why? \_\_\_\_\_

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the information that I have given today is correct to the best of may knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_

Date \_\_\_\_\_

I verbally reviewed the medical / dental information above with patient named herein.  
  
Doctor's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL HISTORY UPDATES

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Initials: \_\_\_\_\_

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Initials: \_\_\_\_\_

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Initials: \_\_\_\_\_

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Initials: \_\_\_\_\_