MEDICAL HISTORY

Name_____ **Birthdate** _____

In the past 10 years have you been hospitalized or had a major operation? ❑ Yes ❑ No

If yes, please explain: _____

Have you had any serious illnesses? ❑ Yes ❑ No If yes, describe _____

Are you currently taking any medication(s)? ❑ Yes ❑ No If yes, please list _____

Have you taken Phen-fen or Redux? ❑ Yes ❑ No

Have you ever taken Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone? ❑ Yes ❑ No

Do you need pre-medication before any treatment can be done? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No Do you use cocaine or other recreational drugs? ❑ Yes ❑ No

Are you allergic to any of the following? ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa drugs

❑ Other If yes, please explain: _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints, Pins, etc.
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemical Dependency (Past or Current)
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cold Sore/Fever Blisters
- ❑ Congenital Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Depression
- ❑ Diabetes
- ❑ Eating Disorders
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Jaw Pain
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory (Lung) Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus Problems
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

Do you have any disease, condition or problem not listed above that you think I should know about? ❑ Yes ❑ No

If yes, please explain: _____

DENTAL HISTORY

Reason for Visit? _____

Specific Dental Concerns? _____

Date of last dental care and treatment received _____ Date of last dental X-rays _____

Have you ever had any severe reaction to dental treatment or local anesthetics? ❑ Yes ❑ No

Check (✓) if you have had problems with any of the following:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or Popping Jaw
- ❑ Food Collection Between Teeth
- ❑ Grinding Teeth
- ❑ Loose Teeth or Broken Fillings
- ❑ Periodontal Treatment
- ❑ Sores or Growths in your Mouth
- ❑ Sensitivity to Hot
- ❑ Sensitivity to Sweets
- ❑ Sensitivity when Biting
- ❑ Sensitivity to Cold

If you could change **ANYTHING** about your smile, what would you change?_____

_____

I hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical condition or in medications I take can affect dental treatment, I understand the importance of and agree to take the responsibility to inform the dentist of any changes in my or my dependents health at any subsequent appointments.

Signature_____ **Date** _____

(Patient, legal guardian or authorized agent of patient)

Dr. Signature_____ **Date** _____