



MEDICAL/DENTAL HISTORY

Patient's Name: _____ Birthdate: _____

1. Are you in good health? Yes No

2. Are you now under the care of a physician? Yes No

If yes, for what condition? _____

3. In the past five years have you been hospitalized for a major operation or illness? Yes No

If yes, please explain? _____

4. Physician: _____ Phone #: _____

Former Dentist: _____ City: _____ Phone #: _____

5. Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney / liver trouble	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (Type____)	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	ADHD medications	<input type="checkbox"/>	<input type="checkbox"/>
AIDS / HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction / alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic joints	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

6. Has a physician ever recommended antibiotics before dental treatment? Yes No

7. List any prescription and / or over the counter medications you are currently taking

Taking _____ for _____ Taking _____ for _____

Taking _____ for _____ Taking _____ for _____

Have you ever taken any of the following medications (Actonel, Aredia, Bonafos, Boniva, Didronel, Fosamax, Ostac, Skelid, Zometa)? Yes No How long? _____

8. Do you smoke? Yes No Do you chew tobacco? Yes No If yes, how long? _____

9. Are you allergic to or have you had a reaction to:

- Local Anesthetics (Novacaine)
- Penicillin or other Antibiotics
- Codeine or other Narcotics
- Aspirin
- Latex
- Other _____

10. (Women) Are you pregnant? Yes No If yes, _____ months. Are you nursing? _____

11. Have you had any serious trouble associated with previous dental treatment? Yes No

If yes, explain: _____

12. Are you having any dental discomfort or concerns? Yes No

If yes, explain: _____

13. Do you have any of the following?

- Growths, sores or swollen areas
- Bleeding gums
- Teeth sensitive to heat, cold, or sweets
- Pain or discomfort while chewing
- Jaws click, crack, lock or pop
- Clench or grind your teeth
- Pain in or near ear
- Bad breath
- Stained or discolored teeth
- Cracked teeth
- Ill-fitting partials or dentures

Is there anything you would like to change about your smile? _____

I hereby certify that the above information is true and correct

Signed: _____ Date: _____

Patient (Parent/Guardian if under 18)