

Medical History

Name _____ Age _____ Date _____
 Medical _____ M.D.'s _____
 Doctor _____ Phone _____

Please rate your health on a scale of 1-10.
 Poor Average Excellent
 1 2 3 4 5 6 7 8 9 10

Have you been examined by a physician in the past 2 years? Yes No

Have you had a physical in the past two years? Yes No

Do you have any medical problems? Yes No
 If so, please list below.

Are you taking any medications now? Yes No
 If so please list name(s) and reasons for taking them (include all non-prescription drugs i.e. aspirin, nuprin, Tylenol, etc.).

Are you taking or have you ever taken prescription diet drugs? (Phen-fen or Redux) Yes No

Are you now or have you ever taken bisphosphonates (drugs that effect your bone density)? Yes No

Are you sensitive or allergic to: latex rubber, local anesthetic (freezing), novocaine, xylocaine, penicillin, codeine, aspirin, or any other medications? Yes No

Do you have trouble walking up One flight of stairs? Yes No

Have you ever had an unfavorable reaction following Dental Treatment? Please discuss with the Doctor. Yes No

Have you ever had excessive bleeding requiring special treatment? Please discuss this with the Doctor. Yes No

Female patients, are you or could you be pregnant or nursing? If pregnant, which month? Yes No

Are you taking birth control pills? Yes No

Do you have any disease, condition or problem not listed that you think we should know about? _____

Do you have or have you had any of the following?
 (Please circle known conditions)

- | | |
|-------------------------|--|
| Heart Trouble/Angina | Migraine/Headaches |
| Heart Murmur | Emphysema |
| Asthma | Herpes |
| Diabetes | Mitral Valve Prolapse |
| Arthritis | Artificial Valve, Joint, or Prosthesis |
| Jaundice | Blood Transfusions |
| Stroke | Tuberculosis(TB) |
| Hemophilia | Stomach Ulcer |
| Epilepsy | Kidney Disease |
| Glaucoma | Fainting Spells |
| Hepatitis (A,B, or C) | Sinus Trouble |
| Venereal Disease | Tumors or Growths |
| Congenital Heart Defect | Neck Injury |
| Cardiac Pacemaker | Cancer Treatment |
| High Blood Pressure | Sickle Cell Disease |
| Date Taken _____ | Liver Disease |
| Result _____ | Thyroid Disease |
| Anemia | Alcoholism |
| Rheumatic Fever | Addictions |
| Lupus | TMJ Problems |
| Nervous Disorders | HIV+ /AIDS |
| Cortisone Treatment | Colitis |
| Psychiatric Treatment | |

Dental History

Purpose of this visit/ Primary complaint: _____

Are you presently in pain? Yes No
 _ Teeth _ Jaw _ Left Side _ Other
 _ Gums _ Face _ Right Side
 If so, how long? _____

Do you have any facial swelling? Yes No

Is any part of your mouth sensitive to the following?
 _ Hot _ Sweets _ Brushing _ Air
 _ Cold _ Biting Pressure _ Flossing

Do you clench and grind your teeth? _ Day _ Night

Are you aware of clicking or popping?
 _ Left _ Right

Do you have any growths or swelling in your mouth?
 Where? _____

Do you have any unpleasant odor or taste in your mouth? _____

I hereby state that the above medical and dental history is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medications change, I will inform the Doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

Signed: _____
 Date: _____