

MEDICAL HISTORY

Are you under a physician's care now? Yes No N/A _____

Have you ever been hospitalized or had a major operation? Yes No N/A _____

Have you ever had a serious head or neck injury? Yes No N/A _____

Are you taking any medications, pills or drugs? Yes No N/A _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No N/A _____

Are you on a special diet? Yes No N/A _____

Do you use tobacco? Yes No N/A _____

Do you use controlled substances? Yes No N/A _____

Women: Are you Pregnant/trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have, or have you had, any of the following? _____

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Radiation Treatments | |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Recent Weight Loss | |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Renal Dialysis | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever* | |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatism | |

* Condition may require medication

Have you ever had any serious illness not listed on a previous page Yes No N/A _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I give my consent to needed services and use of proper and acceptable methods to complete same and accept responsibility for payment of services performed.

Signature of Patient, Parent or Guardian

Date

Signature of Doctor

Date

DENTAL HISTORY

Please check any of the following problems that apply to you

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw Joint pain
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifted teeth
- Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- Dentures
- Partial Dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

- Your last cleaning ____/____/____
- Your last oral cancer screening ____/____/____
- Your last complete X-Rays ____/____/____

Name of previous dentist?

City: _____ **State:** _____

Phone Number: _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

Do you smoke or use chewing tobacco? _____

How much? _____

How long? _____

Please check any of the following problems that apply to you

- Make them brighter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth colored fillings
- Repair chipped teeth
- Replace missing tooth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1—10, with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?
