

Medical History

Do you have a personal physician? Yes No

Physician Name: _____ Phone: _____

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

If yes, explain: _____

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

Are you presently taking any drugs prescribed by a physician or dentist? Yes No If yes, explain: _____

Have you had major surgery? Yes No

(If female) Are you taking hormones or birth control? Yes No

Are you pregnant? Yes No — Are you nursing? Yes No

Do you need to pre-medicate with antibiotics for dental treatment? Yes No

Are you allergic to: Penicillin Codeine Local Anesthetics Latex Other _____

Are you taking any blood thinners? Yes No

HAVE YOU HAD OR DO YOU NOW HAVE:

	Yes	No		Yes	No
AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (A or B or C)	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged cough	<input type="checkbox"/>	<input type="checkbox"/>
Drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>

Have you any disease, condition, or problem not previously listed? _____

Dental History

When was your last dental visit? _____

Who was your last dentist? _____ Phone: _____

Are you having any dental problems that require immediate attention? _____

Do your gums bleed when brushing? _____ Are they tender or swollen? _____

Have you had periodontal or gum treatment? _____ When? _____

Have you ever had orthodontic treatment (braces)? _____ When? _____

How do you feel about the appearance of your smile? _____

Have you ever had an unpleasant dental experience? _____

ALL TREATMENT IS BY APPOINTMENT. A NO-SHOW FEE WILL BE CHARGED FOR MISSED APPOINTMENTS.

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.		
_____ SIGNATURE OF RESPONSIBLE PARTY	_____ DATE	_____ RELATIONSHIP TO PATIENT(S)