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Please answer questions completely. All information is confidential.

Medical History

Patient Name: _____ Date of Birth: _____

Primary Physician name, address and telephone number: _____

_____

Date of last medical exam: _____ Reason: _____
Name and address of any other Physicians you see: (Include Specialists): _____

_____

List all medications, **including non-prescriptions**, you are now taking:

_____

_____

_____

List any time you have been hospitalized, and for what reason:

_____

Please circle Yes or No if you have (or have ever had) any of the following conditions:

Yes	No	Alcohol habit	Yes	No	Glaucoma	Yes	No	Psychiatric care
Yes	No	Anemia	Yes	No	Heart attack	Yes	No	Radiation treatment
Yes	No	Arthritis	Yes	No	Heart disease	Yes	No	Respiratory problems
Yes	No	Asthma	Yes	No	Heart murmur	Yes	No	Rheumatic fever
Yes	No	Diabetes	Yes	No	Hepatitis	Yes	No	Sexually transmitted disease
Yes	No	Cardiac pacemaker	Yes	No	HIV, AIDS	Yes	No	Smoking habit
Yes	No	Cancer	Yes	No	High Blood Pressure	Yes	No	Stomach problems-Ulcers
Yes	No	Chest pain	Yes	No	Immune suppressive disorders	Yes	No	Stroke
Yes	No	Circulation problems	Yes	No	Joint replacement	Yes	No	Thyroid problems
Yes	No	Drug habit	Yes	No	Kidney disease	Yes	No	Tuberculosis
Yes	No	Emphysema	Yes	No	Leukemia	Other: _____		
Yes	No	Epilepsy	Yes	No	Mitral valve prolapse	_____		

Circle answer.

Yes No Have you had general anesthesia in the past 10 years?
Yes No Have you been given steroid (Prednisone) therapy within the past 2 years?
Yes No Have you ever had an allergic reaction when taking penicillin, any other antibiotics, codeine, aspirin, sulfa drugs, or any other medication?

List any known allergies: _____

Yes No Have you ever had any problems with local anesthetics, such as novocaine?
Yes No Have you ever been told you need to take antibiotics before you have dental work done?
Yes No Have you a tendency to prolonged bleeding?
Yes No Are you subject to fainting, dizziness, nervous disorders?
Yes No Females only: Are your pregnant or nursing?

Please continue to other side of this form.

Dental History

Name of General Dentist: _____

Last visit date: _____ Reason for visit: _____
Date of last dental x-rays: _____ Date of last teeth cleaning: _____

If you have changed Dentists recently, give name of previous Dentist:_____

Do you have tooth or gum pain at the present time? If yes, explain:

_____

Have you ever had any serious problem associated with previous dental treatment? If yes, explain:

_____

How often do you brush your teeth? _____ times per day Do you floss daily? _____
What other dental aids or tools do you use? _____

Circle answer.

Yes No Do your gums bleed when you brush your teeth?
Yes No Do your gums bleed when you floss your teeth?
Yes No Do you avoid brushing any part of your mouth because of pain, or sensitivity?
If yes, explain: _____

Do you feel twinges of pain when your teeth come in to contact with:

Yes No - hot foods or liquids? (such as coffee, tea, soups, etc.)
Yes No - cold foods or liquids? (such as ice cream, cold fruit, etc.)
Yes No - sweet foods? (such as candy, sweet desserts, etc.)
Yes No - sour foods? (such as lemons, limes, grapefruit, etc.)
Yes No Do you feel pain to any of your teeth when brushing or flossing them?
Yes No Do you chew on only one side of your mouth? If yes, explain: _____
Yes No Do your gums feel tender or swollen?
Yes No Do you clench or grind your jaws while sleeping, or during the day?
Yes No Do your jaws ever feel tired?
Yes No Do you have headaches? If yes, do you wake up with them at night? _____
Number of times per month? _____
Yes No Do you wear dentures? Uppers____ Lowers____
Yes No Do you wear partials? Uppers____ Lowers____
Yes No Do you usually have many cavities?
Yes No Do you break or lose fillings easily?
Yes No Do you gag easily?
Yes No Have you ever been treated for periodontal disease in the past?
If yes, explain: _____
Yes No Are you considering an implant to replace a missing tooth?
Yes No Are you familiar with the term "preventive dentistry"?

Other dental information you wish to share: _____

_____ _____
Patient signature (or Guardian, if minor) Date