

MEDICAL HISTORY

1. Are you in good health? yes no Date of Last Physical Examination? _____
2. Are you now under the care of a physician? If so, why? _____ yes no
3. Physicians name and address: _____
4. Have you ever had a serious illness or operation? If so, what? _____ yes no
5. Have you ever been hospitalized? If so why? _____ yes no
6. Do you have chest pain upon exertion? _____ yes no
7. Are you ever short of breath upon mild exercise? _____ yes no
8. Have you ever taken Fosamax or any other Bisphosphonate? _____ yes no
9. Are you taking blood thinners / Coumadin _____ yes no
10. Do you wear a cardiac pacemaker? _____ yes no
11. Have you ever had heart surgery? _____ yes no
12. Have you had a joint replacement?, If yes what? _____ yes no
13. Are you taking any drugs or medications? _____ yes no
List Medications and reason for taking them: _____
14. Are you allergic or have you reacted adversely to any of the following : (Circle Y for Yes and N for No)

Y N Penicillin	Y N Sulfa Drugs	Y N Percodan	Y N Local Anesthetic	Y N Latex
Y N Tetracycline	Y N Aspirin	Y N Valium	Y N Novacaine	Y N Other _____
Y N Erythromycin	Y N Codeine	Y N Nitrous Oxide	Y N Xylocaine	_____
15. Have you ever had any of the following: (Circle Y for Yes and N for No)

Y N Anemia	Y N Thyroid Disease	Y N Radiation Treatment	Y N Pain in jaw joints
Y N Heart Murmur	Y N Bleeding Problems	Y N Allergies	Y N HIV positive
Y N Heart Failure	Y N Hemophilia	Y N Hives or Skin Rash	Y N Epilepsy
Y N Heart Disease	Y N Bruise Easily	Y N Asthma or Hay Fever	Y N Mental Disorders
Y N Heart Attack	Y N Rheumatic Fever	Y N Fainting or Seizures	Y N Psychiatric Care
Y N Angina Pectoris	Y N Scarlet Fever	Y N Artificial Joint	Y N Stroke
Y N Mitrovalve Prolapse	Y N Blood Diseases	Y N Arthritis/Rheumatism	Y N Glaucoma
Y N Artificial Heart Valve	Y N Hepatitis A (Infectious)	Y N Head Injuries	Y N Herpes
Y N Congenital Heart Disease	Y N Hepatitis B (Serum)	Y N Stomach Ulcers	Y N Cold Sores
Y N High Blood Pressure	Y N Jaundice/Liver Disease	Y N Difficulty in Swallowing	Y N Sinus Trouble
Y N Respiratory Disease	Y N Kidney Disease	Y N Venereal Disease	Y N Ankle Swelling
Y N Tuberculosis	Y N Tumors or Growths	Y N Drug Addiction	Y N Other _____
Y N Nervous Disorder	Y N Cancer	Y N Blood Transfusion	_____
Y N Diabetes	Y N Chemotherapy	Y N AIDS (Acquired Immune Deficiency Syndrome)	_____
16. Do you smoke, chew tobacco, or use any tobacco product? If yes, what and how much _____ yes no
17. Do you use any alcohol products? If yes, how much? _____ yes no
18. (Women) Are you pregnant? If yes, how many months? _____ yes no 19.
- (Women) Are you taking birth control? If so, what? _____ yes no
20. Have you ever taken an antibiotic or has your M.D. ever told you to take an antibiotic for dental care? yes no

DENTAL HISTORY

1. Please describe the reason for your appointment today: _____
2. Are you in discomfort at this time? _____ yes no
3. Have you ever had a serious problem associated with previous dental treatment? _____ yes no
If yes, please explain: _____
4. Do you have, or have you had any of the following? (circle Y for Yes or N for No)

Y N Pain in jaw (TMJ)	Y N Bleeding sore gums	Y N Orthodontics (braces)	Y N Sensitive to hot
Y N Clicking / popping jaw	Y N Burning tongue / lips	Y N Loose teeth	Y N Sensitive to cold
Y N Difficulty opening jaw	Y N Bad taste / breath	Y N Clenching or grinding	Y N Sensitive to sweet
Y N Difficulty closing jaw	Y N Blisters on lips or mouth	Y N Periodontal (gum) disease	Y N Sensitive to biting
5. Does dental treatment make you nervous? No Slightly Moderately Extremely
6. How do you routinely care for your teeth? Brush Floss Water-Pik Fluoride rinse/gel Other
7. How long has it been since your last full mouth x-rays? _____
8. Previous Dentist: _____ Date of last visit: _____
Phone number: _____ City, State: _____
9. Are you happy with your smile? _____ yes no
10. Would you like your teeth to be whiter? _____ yes no

Signature of Patient _____

Date _____

Signature of Dentist _____

Date _____