Medical History

Your current physical health is ☐Good ☐Fair ☐Poor

Do you Smoke or use tobacco in any other form ☐Yes ☐No
Are you taking any prescription/over-the-counter or herbal supplement drugs? Please List each one:_____

_____

For Women: Are you taking Birth Control Pills? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No If yes, # of weeks _____

Are you Nursing? ☐Yes ☐No

Have you had any of the following diseases or medical problems?

Please Check

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Please list any serious medical condition(s) that you have ever had?

_____

_____

Are you allergic to any of the following?

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other : _____

Dental History

Why have you come to the dentist today?_____

_____

Are you having any pain or discomfort at this time? ☐Yes ☐No

Are you nervous about having dental treatment? ☐Yes ☐No

Do you have difficulty or pain when opening your mouth wide? ☐Yes ☐No

Does your jaw get stuck, locked, or go out? ☐Yes ☐No

Are you aware of any noises in the jaw joint? ☐Yes ☐No

Do you have pain in the area from your temple to your ears? ☐Yes ☐No

Do you have frequent headaches? ☐Yes ☐No

Have you recently had an injury to your head, neck, or jaw? ☐Yes ☐No

Have you ever had treatment for a jaw joint problem? ☐Yes ☐No

Have you ever had braces? ☐Yes ☐No

What type of tooth brush do you use _____

Are your teeth sensitive to heat, cold, or anything else? ☐Yes ☐No

Do your gums bleed when you brush? ☐Yes ☐No

Are you happy with your smile? ☐Yes ☐No

Do you have any of the following habits? Please check

- ❑ Nail biting
- ❑ Thumb/finger sucking
- ❑ Tooth Picking
- ❑ Gum chewing
- ❑ Teeth grinding/Clenching
- ❑ Snoring/Sleep Apnea
- ❑ Cheek Biting
- ❑ Tongue Thrusting
- ❑ Mouth Breathing
- ❑ Bulimia/Anorexia
- ❑ Substance Abuse

Other:_____

Is there anything you would like to discuss with the doctor in private? ☐Yes ☐No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. ☐Yes ☐No

_____

Signature Date

Comments:

I verbally reviewed the medical/dental information above with the patient named herein. Inials:_____ Date:_____

I have read my medical history dated _____ and confirm that it states past and present medical conditions. _____

Signature Date

I have read my medical history dated _____ and confirm that it states past and present medical conditions. _____

Signature Date

I have read my medical history dated _____ and confirm that it states past and present medical conditions. _____

Signature Date

I have read my medical history dated _____ and confirm that it states past and present medical conditions. _____

Signature Date