

## MEDICAL HISTORY

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Male Female

Reason for today's visit \_\_\_\_\_

Have you been a patient in the hospital during the past two years? \_\_\_\_\_

If so, for what condition? \_\_\_\_\_

List any herbals, prescriptions or non-prescription drugs you are taking \_\_\_\_\_

List any medications you are sensitive or allergic to \_\_\_\_\_

Have you taken any appetite suppression? i.e. fenphen \_\_\_\_\_

Are you on a special diet? \_\_\_\_\_

Physician's name and phone number \_\_\_\_\_

### DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
Aids/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Implants	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hives	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Latex or Metal	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Type? _____	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash/Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Habit	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>				Venereal Disease/STD	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>						

Please list any disease, condition or problem not listed \_\_\_\_\_

### FOR WOMEN ONLY

Are you on birth control pills?

Are you pregnant?

Are you nursing?

Are you on hormone replacement therapy?

### DENTAL HISTORY

	Yes	No
Are your teeth sensitive to HEAT COLD SWEETS BITING PRESSURE?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have your teeth cleaned regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Have your gums been treated surgically?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to keep your natural teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you like the looks of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken antibiotic premedication for dental treatment in the past?	<input type="checkbox"/>	<input type="checkbox"/>

Do you or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Injury to face or jaw	<input type="checkbox"/>	<input type="checkbox"/>	Do you grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Facial pain	<input type="checkbox"/>	<input type="checkbox"/>	Clicking or popping in jaw	<input type="checkbox"/>	<input type="checkbox"/>	Chronic head, jaw or neck pain	<input type="checkbox"/>	<input type="checkbox"/>

Do you have fear of dental treatment? (circle one) MILD MODERATE SEVERE

Date of last dental exam and x-rays \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT SIGNATURE IF PATIENT IS A MINOR \_\_\_\_\_