

Medical History

Name _____

Physician's Name _____ Phone _____ Date of Last Visit _____

Circle Yes or No (Y or N) if you have ever had any of the following:

- | | | |
|-----------------------------|---------------------------------|-----------------------------------------|
| Y--N AIDS or HIV positive | Y--N Glaucoma | Heart Problems |
| Y--N Acid Reflux/ G.E.R.D | Y--N Hepatitis, Type: _____ | Y--N Low blood pressure |
| Y--N Arthritis, Type: _____ | Y--N Kidney problems | Y--N High blood pressure |
| Y--N Artificial joints | Y--N Liver problems or Jaundice | Y--N Pacemaker |
| Y--N Asthma | Y--N Lung or breathing problems | Y--N Artificial valves |
| Y--N Cancer | Y--N Sinus trouble | Y--N Infective (Bacterial) Endocarditis |
| Y--N Chemical Dependency | Y--N Smoking/chewing tobacco | Y--N Congenital heart defects |
| Y--N Diabetes, Type: _____ | Y--N Stroke | Y--N Heart Surgeries |
| Y--N Eating disorder | Y--N Swollen neck glands | Y--N Other _____ |
| Y--N Epilepsy | Y--N Thyroid problems | Y--N Serious illnesses/hospitalizations |
| Y--N Excessive bleeding | Y--N Tuberculosis | Y--N Currently under a physician's care |
| | | Y--N Antibiotics for dental treatment |

Give details of the above 'Yes' items _____

Women:
Are you pregnant? _____ Due when? _____
Are you nursing? _____

ALLERGIES Circle if you are allergic to:
Aspirin – Codeine – Latex – Local anesthetic – Penicillin – Sulfa
Other allergies: _____

MEDICATIONS: Please list medications you are currently taking and why:

Dental History (New Patients Only)

Circle if you have ever had any of the following:

- | | | | |
|----------------------------------|----------------------------|----------------------------------|----------------------|
| Bad breath problem | Canker sores in mouth | Orthodontics (braces) | Oral surgery |
| Frequent headaches, neck aches | Cold sores on outer lips | Full dentures / Partial dentures | Excessive gag reflex |
| TMJ, jaw joint pain or treatment | Dental anesthetic problems | Biteguard / Nightguard | Fear of dental care |
| Gum disease treatment | | | |

Circle if you currently have any of the following:

- | | | | |
|------------|-------------------------|----------------------------|----------------------------------|
| Pain | Sensitivity to: | Dry mouth | Clicking or popping jaw |
| Toothache | heat – cold – biting | Mouth breathing | Clenching or grinding of teeth |
| Vague ache | sweets – pressure | Sores or growths in mouth | Tired, sore or painful jaw joint |
| Swelling | Broken tooth or filling | Bleeding gums | Pain around ear |
| | Loose tooth | Food packing between teeth | Other: _____ |

Give details and location of the above circled items _____

How often do you brush? _____ floss? _____ What type toothbrush do you use? Ultrasoft – Soft – Medium – Hard – Electric

Would you like improve the appearance of your smile? _____ How? _____

Reason for today's visit _____

Former Dentist _____ City/State _____ Phone _____

Date and reason of last dental visit _____ Date of last dental X-rays _____

What have you liked about any dental office you've been to? _____ Least? _____

TREATMENT AUTHORIZATION

I have reviewed the information on both sided of this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

Signature (Parent/Guardian if under age 18)

Relationship (if patient is under age 18)

Date