MEDICAL HISTORY

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ____________________

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No

Please list each one: ____________________

____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: __________

Are you nursing? ❑ Yes ❑ No

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

Y	N	Anemia/Radiation Treatment	Y	N	Heart Surgery/Pacemaker
Y	N	Artificial Bones/Joints	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Artificial Valves	Y	N	Hepatitis
Y	N	Asthma/Arthritis	Y	N	High/Low Blood Pressure
Y	N	Blood Transfusion	Y	N	HIV+/AIDS
Y	N	Cancer/Chemotherapy	Y	N	Hospitalized for any reason
Y	N	Congenital Heart Defect	Y	N	Kidney Problems
Y	N	Diabetes/Tuberculosis (TB)	Y	N	Mitral Valve Prolapse
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Drug/Alcohol Abuse	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema /Glaucoma	Y	N	Severe/Frequent Headaches
Y	N	Epilepsy/Seizures/Fainting	Y	N	Shingles
Y	N	Fever Blisters/Herpes	Y	N	Sinus Problems
Y	N	Heart Attack/Stroke	Y	N	Ulcers/Colitis
Y	N	Heart Murmur	Y	N	Venereal Disease

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs that you are allergic to: ____________________

____

DENTAL HISTORY

Why have you come to the dentist today? ____________________

____

____

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? ___ a day do you brush? ___

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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

Doctor's Comments: ____________________

____

MEDICAL HISTORY UPDATE

1. Date: __________ Comments: ____________________ Signature: ____________________
2. Date: __________ Comments: ____________________ Signature: ____________________
3. Date: __________ Comments: ____________________ Signature: ____________________