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## MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

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

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

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Have you had any metal rods, pins or implants?  Yes  No

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

Please list each one: \_\_\_\_\_

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin)  Yes  No

If so, when? \_\_\_\_\_

Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No

**For Women:** Are you using a prescribed method of birth control?  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 Abnormal Bleeding / Hemophilia     | Y N Herpes / Fever Blisters      |
| Y N AIDS                               | Y N High Blood Pressure          |
| Y N Alcohol / Drug Abuse               | Y N HIV +                        |
| Y N Anemia                             | Y N Hospitalized for Any Reason  |
| Y N Arthritis                          | Y N Kidney Problems              |
| Y N Artificial Bones / Joints / Valves | Y N Liver Disease                |
| Y N Asthma                             | Y N Low Blood Pressure           |
| Y N Blood Transfusion                  | Y N Lupus                        |
| Y N Cancer / Chemotherapy              | Y N Mitral Valve Prolapse        |
| Y N Colitis                            | Y N Pacemaker                    |
| Y N Congenital Heart Defect            | Y N Psychiatric Problems         |
| Y N Diabetes                           | Y N Radiation Treatment          |
| Y N Difficulty Breathing               | Y N Rheumatic / Scarlet Fever    |
| Y N Emphysema                          | Y N Seizures                     |
| Y N Epilepsy                           | Y N Shingles                     |
| Y N Fainting Spells                    | Y N Sickle Cell Disease / Traits |
| Y N Frequent Headaches                 | Y N Sinus Problems               |
| Y N Glaucoma                           | Y N Stroke                       |
| Y N Hay Fever                          | Y N Thyroid Problems             |
| Y N Heart Attack / Heart Surgery       | Y N Tuberculosis (TB)            |
| Y N Heart Murmur                       | Y N Ulcers                       |
| Y N Hepatitis                          | Y N Venereal Disease             |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

### Are you allergic to any of the following?

- |                        |                    |                  |
|------------------------|--------------------|------------------|
| Y N Aspirin            | Y N Erythromycin   | Y N Penicillin   |
| Y N Codeine            | Y N Jewelry/Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex          | Y N Other        |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

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

### MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N  
If Yes, please explain. \_\_\_\_\_

Has there been any change in your health status since your last visit? Y N  
If Yes, please explain. \_\_\_\_\_

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## DENTAL HISTORY

### Why have you come to the dentist today?

Are you currently in pain?  Yes  No

Do you require antibiotics before dental treatment?  Yes  No

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

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

Do you floss daily?  Yes  No Brush daily?  Yes  No

Type of bristles on your toothbrush?  Hard  Medium  Soft

Have you ever had gum treatment?  Yes  No

Do your gums ever bleed?  Yes  No Ever Itch?  Yes  No

Have you ever had periodontal disease?  Yes  No

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

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Do you have any loose teeth?  Yes  No

Do you still have wisdom teeth?  Yes  No

Would you like fresher breath?  Yes  No Whiter teeth?  Yes  No

**Are you happy with the way your smile looks?**  Yes  No

If not, what would you change? \_\_\_\_\_

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 \_\_\_\_\_

## OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_