MEDICAL HISTORY

Do you have or have you had any of the following:

- ❑ Valve or Joint Replacement
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Mitral Valve Prolapse
- ❑ Heart Murmur
- ❑ Pacemaker
- ❑ Heart Disease
- ❑ Angina Pectoris
- ❑ Bleeding Problems
- ❑ Cigarette, Pipe or Cigar Smoking
- ❑ Asthma
- ❑ Diabetes
- ❑ Epilepsy or Seizures
- ❑ Kidney Disease
- ❑ Ulcers
- ❑ Hepatitis/Liver Disease
- ❑ Tuberculosis
- ❑ Blood Transfusions
- ❑ Latex Sensitivity
- ❑ Dry Mouth
- ❑ Aids/HIV Positive
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Anemia
- ❑ Stroke
- ❑ Sinus Problems
- ❑ Radiation Treatment
- ❑ Chemical Dependency
- ❑ Allergies to Anesthetics
- ❑ Arthritis

WOMEN: Are you

❑ Pregnant ❑ Yes _____ months ❑ No ❑ Nursing ❑ Yes ❑ No ❑ Taking birth control pills? ❑ Yes ❑ No

List any other significant medical history_____

DENTAL HISTORY

Do you have or have you had:

- ❑ Tooth sensitivity to heat, cold, sweets, or pressure
- ❑ Food impaction between teeth
- ❑ A reaction to a dental injection
- ❑ Bleeding gums
- ❑ Loose teeth
- ❑ Orthodontic (braces) treatment
- ❑ Headaches, earaches, or popping of your jaw
- ❑ Complications from dental extractions
- ❑ Periodontal (gum) disease or treatment

Are you satisfied with the appearance of your teeth and smile? ❑ Yes ❑ No

If not, would you like

- ❑ Whiter teeth
- ❑ Straighter teeth
- ❑ To close spaces between your teeth
- ❑ Have silver fillings replaced with tooth-colored restorations
- ❑ Other desired improvements _____

Reason for seeing the Doctor today _____

Date of: Last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

Your previous Dentist's name _____

Do you feel nervous about having dental treatment? ❑ Yes ❑ No

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? ❑ Yes ❑ No

If yes, describe _____

Is there anything else about having
dental treatment you would like us to know?_____

MEDICATIONS

	Current Medications	Reason for Taking		Current Medications	Reason for Taking
1.			4.		
2.			5.		
3.			6.		

Medications you are allergic to: _____

I attest that to the best of my knowledge the information provided above is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next dental visit following the change.

Signature_____ ❑ Patient ❑ Parent ❑ Guardian