Medical History

Are you currently under the care of a physician? If yes, for what reason? Physician's name?
O Yes O No _____

Are you taking any prescription or over-the-counter medications? If yes, please list.
O Yes O No _____

Do you smoke or use tobacco in any other form? If yes, how much?
O Yes O No _____

Do you take aspirin on a daily basis? Yes No

Have you ever had any of the following diseases or medical problems? If "yes", please circle.

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 Spells	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

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

Please list any drugs that you are sensitive/ allergic to:
_____

For Women:
Taking birth control pills? O Yes O No Pregnant? O Yes O No Nursing? O Yes O No Taking Bone Density Meds O Yes O No

Dental History

Why have you come to the dentist today?_____

Are you currently in pain? O Yes O No

Have you ever had a serious problem associated with previous dental work? O Yes O No _____

Have you ever had gum treatment? O Yes O No If yes, when? _____

Do you ever experience pain in your jaw joint (TMJ/ TMD)? O Yes O No

How often do you have your teeth cleaned? _____ Last cleaning? _____

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.

_____
Signature Date

OFFICE USE ONLY:
I have verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____