MEDICAL / DENTAL HISTORY

Address/phone 2. Are you under a physician's care? Since when	1.	Primary physician's name Date of last visit					
2. Are you under a physician's care? Since when Why		Address/phone					
3. Are you taking any medications or substances (including vitamins/herbs) YES NO (If yes, please list medications in section to the right) 4. Are you allergic to any medications or substances? YES NO 5. Do you have any other allergies? YES NO 6. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? YES NO 7. Are you sensitive to any metals or latex? YES NO 8. Are you pregnant or suspect you may be? YES NO 9. Do you have or have you had any of the following medical conditions? (Check all that apply): Heart attack/chest pain Blood disorder (anemia/hemophilia) Epilepsy/Seizure disorder replacement surgery Stroke Asthma/difficulty breathing Artificial heart valve Cancer/chemotherapy Thyroid problem Psychiatric treatment Psychi	2.	Are you under a physician's care?		☐ YES	□ NO	·	
(If yes, please list medications in section to the right) 4. Are you allergic to any medications or substances?		Since when Why					
5. Do you have any other allergies?	3.			☐ YES	□ NO		
6. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? YES NO	4.	Are you allergic to any medications or substances?		☐ YES	□ NO		
7. Are you sensitive to any metals or latex?	5.	Do you have any other allergies?		☐ YES	□ NO		
7. Are you sensitive to any metals or latex?	6.						
8. Are you pregnant or suspect you may be? 9. Do you have or have you had any of the following medical conditions? (Check all that apply): Heart attack/chest pain Blood disorder (anemia/hemophilia) Epilepsy/Seizure disorder replacement surgery Stroke Asthma/difficulty breathing Thyroid problem Artificial heart valve Cancer/chemotherapy Thyroid problem Heart valve disease Diabetes Drug/alcohol abuse Pacemaker Tuberculosis Psychiatric treatment (including depression & panic attacks) Abnormal bleeding Hepatitis B/Hepatitis C 10. Do you smoke? YES NO If yes, how long and how much? YES, how long and how much? If no longer, when did you quit? 11. Do you have or have you had any of the following dental conditions? (Check all that apply): Growths, sores or swollen areas in your mouth Jaws click, crack, lock or pop Bleeding gums Clench or grind your teeth Periodontal (gum) treatment Any teeth sensitive to heat, cold or sweets				☐ YES	□ NO		
9. Do you have or have you had any of the following medical conditions? (Check all that apply): Heart attack/chest pain	7.	Are you sensitive to any metals or latex?		☐ YES	□ NO		
Heart attack/chest pain	8.	Are you pregnant or suspect you may be?		☐ YES	□ NO		
Artificial joint	9. Do you have or have you had any of the following medical conditions? (Check all that apply):						
If yes, how long and how much? If no longer, when did you quit? If you answered YES to any of the questions please elaborate as needed in the space provided below: If you answered YES to any of the questions please elaborate as needed in the space provided below: If you answered YES to any of the questions please elaborate as needed in the space provided below: If you answered YES to any of the questions please elaborate as needed in the space provided below: If you answered YES to any of the questions please elaborate as needed in the space provided below: If you answered YES to any of the questions please elaborate as needed in the space provided below: If you answered YES to any of the questions please elaborate as needed in the space provided below:	Artificial joint replacement surgeryStrokeAsthma/difficulty breathingThyroid problemPacemakerTuberculosisPsychiatric treatment(including depression & panic attacks)						
If yes, now long and now much? If no longer, when did you quit? 11. Do you have or have you had any of the following dental conditions? (Check all that apply): Growths, sores or swollen areas in your mouth Bleeding gums Clench or grind your teeth Periodontal (gum) treatment Any teeth sensitive to heat, cold or sweets	10.	Do you smoke?		☐ YES	□ NO		
If no longer, when did you quit?		If yes, how long and how much?					
Growths, sores or swollen areas in your mouth Jaws click, crack, lock or pop Bleeding gums Clench or grind your teeth Any teeth sensitive to heat, cold or sweets		If no longer, when did you quit?					
Bleeding gums Clench or grind your teeth Periodontal (gum) treatment Any teeth sensitive to heat, cold or sweets	11. Do you have or have you had any of the following dental conditions? (Check all that apply):						
Periodontal (gum) treatment Any teeth sensitive to heat, cold or sweets	Growths, sores or swollen areas in your mouth Jaws click, crack, lock or pop						
	E	Bleeding gums	_ Clench or grind your teeth				
Rad breath Pain in or near ear	P	Periodontal (gum) treatment	_ Any teeth sensitive to heat, cold or sweets				
Bad steam Tall in or real cal	B	Bad breath					
Orthodontic Treatment	c	Orthodontic Treatment					
12. Do you have a night guard? ☐ YES ☐ NO	12.	Do you have a night guard?		☐ YES	□ NO		
13. Are you having any dental discomfort at this time? ☐ YES ☐ NO	13.	Are you having any dental discomfort at this time?		☐ YES	□ NO		
If yes, please explain:		If yes, please explain:					
14. Name of previous dentist Date of last visit	14.	Name of previous dentist	ne of previous dentist Date of last visit				
15. What type of toothbrush do you use? Battery-powered or manual?	15.	What type of toothbrush do you use?	at type of toothbrush do you use? Battery-powered or manual?				
16. How frequently do you floss? Everyday 4-6x/wk 1-3x/wk Not often	16.	How frequently do you floss? Everyday	4-6x/wk 1-3x/wk	Not o	ften		
17. How frequently do you brush? Everyday Mostly AM/PM Not often	17.	How frequently do you brush? Everyday	Mostly AM/PM	Not o	ften		
18. Do you use a waterpik? ☐ YES ☐ NO	18.	Do you use a waterpik?	use a waterpik? ☐ YES ☐ NO				
19. Is there anything else we should know about your health that was not covered in this form?	19.	Is there anything else we should know about your health that was not covered in this form?					
I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE							
Patient/Guardian's Signature Date							

Dentist's Signature _____

__ Date _____