MEDICAL / DENTAL HISTORY

1. Primary physician's name _____ Date of last visit _____

   Address/phone _____

2. Are you under a physician's care? ☐ YES ☐ NO

   Since when _____ Why _____

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
__ Artificial joint replacement surgery
__ Artificial heart valve
__ Heart valve disease
__ Pacemaker
__ High blood pressure
__ Abnormal bleeding
__ Blood disorder (anemia/hemophilia)
__ Stroke
__ Cancer/chemotherapy
__ Diabetes
__ Tuberculosis
__ HIV+/AIDS
__ Hepatitis B/Hepatitis C
__ Kidney/liver/stomach problems
__ Epilepsy/Seizure disorder
__ Asthma/difficulty breathing
__ Thyroid problem
__ Drug/alcohol abuse
__ Psychiatric treatment (including depression & panic attacks)

10. Do you smoke? ☐ YES ☐ NO

    If 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
__ Bleeding gums
__ Periodontal (gum) treatment
__ Bad breath
__ Orthodontic Treatment
__ Jaws click, crack, lock or pop
__ Clench or grind your teeth
__ Any teeth sensitive to heat, cold or sweets
__ Pain in or near ear

12. Do you have a night guard? ☐ YES ☐ NO

13. Are you having any dental discomfort at this time? ☐ YES ☐ NO

    If yes, please explain: _____

14. Name of previous dentist _____ Date of last visit _____

15. What 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

17. How frequently do you brush? Everyday Mostly AM/PM Not often

18. Do you use a waterpik? ☐ YES ☐ NO

19. Is there anything else we should know about your health that was not covered in this form?

    _____

MEDICATIONS
If more room is needed please attach a copy of your medications.

ADDITIONAL WRITTING ROOM
If you answered YES to any of the questions please elaborate as needed in the space provided below:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____