Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Medical History Form

CHECK THE APPROPRIATE ANSWER **Yes** **No**

1. Are you currently under a physician's care for an acute or chronic condition?? . . . . . _____ _____

   Physician's Name: _____ Address: _____

   Phone: _____

   Last Physical Exam: _____ Why? _____

2. Have you experienced any complications with local anesthetic? . . . . . _____ _____
3. Are you taking any medications (cholesterol lowering, high blood pressure, birth control, etc.)? . _____ _____
   If yes, please list._____
4. Have you taken steroids within the past two years? . . . . . _____ _____
5. Are you allergic to any medications, substances, metals, or latex? . . . . . _____ _____
   If yes, please list._____
6. Are you pregnant or nursing? . . . . . _____ _____
7. Have you been hospitalized or had a serious illness within the past five (5) years? . . . . . _____ _____
   If yes, please explain: _____
8. Are you on a special diet? . . . . . _____ _____
9. Do you regularly use tobacco or tobacco products? . . . . . _____ _____
10. Do you have or have you had any of the following conditions?

	Yes	No	Comments
CARDIOVASULAR:			
Mitral Valve Prolapse	____	____	_____
Heart Murmur	____	____	_____
Rheumatic Fever	____	____	_____
Artificial Hear Valve	____	____	_____
Congenital Heart Defect	____	____	_____
Heart Surgery	____	____	_____
Angina Pectoris	____	____	_____
Myocardial Infarction	____	____	_____
Hypertension	____	____	_____
Heart Pacemaker	____	____	_____
Heart Failure	____	____	_____
Stroke	____	____	_____
RESPIRATORY:			
Tuberculosis	____	____	_____
Emphysema	____	____	_____
Asthma	____	____	_____
MUSCULOSKELETAL:			
Arthritis/Rheumatism	____	____	_____
Bone Disorders	____	____	_____
Artificial Joints/Implants	____	____	_____
ENDOCRINE:			
Diabetes	____	____	_____
Adrenal Disorders	____	____	_____
Thyroid/Parathyroid	____	____	_____

	Yes	No	Comments
GENITOURINARY:			
Kidney Infections	____	____	_____
Venereal Disease	____	____	_____
NEOPLASM/IMMUNO COMPROMISED:			
Cancer	____	____	_____
Chemo/X-ray/Cobalt Tmt	____	____	_____
HIV Infection	____	____	_____
HEMATOPOIETIC			
Bleeding Disorders	____	____	_____
Blood Transfusion	____	____	_____
Excessive Bleeding	____	____	_____
Anemia	____	____	_____
Leukemia	____	____	_____
GASTROINTESTINAL/LIVER:			
Hepatitis A/B/C	____	____	_____
Ulcers	____	____	_____
Liver Disease	____	____	_____
Yellow Jaundice	____	____	_____
NEUROLOGIC:			
Epilepsy	____	____	_____
Seizures	____	____	_____
Fainting/Dizzy Spells	____	____	_____
Psychiatric Treatment	____	____	_____
Drug/Alcohol Addiction	____	____	_____

11. Do you have any disease, condition, or problem not listed? . . . . . _____ _____
    If yes, please explain: _____

DENTAL HISTORY

Chief Dental Complaint: _____

Date of Last Dental Visit: _____ Date of Last Cleaning _____ Date of Last X-Rays: _____

Dentist's Name: _____ Phone: _____

		Yes	**No**
1.	Do you see a dentist regularly?	___	___
2.	Are you having pain or discomfort at this time?	___	___
3.	Are you wearing removable dental appliances?	___	___
4.	Have you ever had a bad experience in the dental office?	___	___
5.	Are any of your teeth sensitive to hot/cold/sweets/biting or chewing?	___	___
6.	Do your gums bleed or hurt?	___	___
7.	Have you experienced any pain/clicking/popping of the jaw joints?	___	___
8.	Have you had periodontal treatment?	___	___
9.	Is your drinking water fluoridated?	___	___
10.	How often do you brush? _____		
11.	How often do you floss? _____		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or medicine(s), I will inform the dental health care provider at the next appointment without fail.

Patient (Guardian) Signature: _____ Date: _____

PLEASE DO NOT WRITE BELOW (to be completed by dental health care provider):

DATE	DRUG NAME	DOSAGE	CLASS	INDICATIONS	DENTAL CONCERNS