MEDICAL HISTORY

DATE:________________

Personal Physician's Name ____

Address ____

Phone: ____

The approximate date of your last doctors visit :____________________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of any physician? ❑ Yes ❑ No

If yes, please explain:____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you presently taking any drugs prescribed by a physician or dentist? ❑ Yes ❑ No

If yes. please list: ____

____

Are you taking aspirin? ❑ Yes ❑ No

Are you taking blood thinners? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No

Have you been told that you need to take antibiotics before dental procedure? ❑ Yes ❑ No

Have you had any serious medical problems in the last 5 years? ❑ Yes ❑ No

If yes, please explain: ____

____

Have you ever had any of the following diseases or medical problems?

Heart Attack	Y N	HIV+/AIDS	Y N
Heart Murmur/Rheumatic	Y N	Shingles	Y N
Fever or other Cardiac Problems	Y N	Kidney Problems	Y N
		Sinus Problems	Y N
Heart Surgery/Pacemaker	Y N	Fever Blisters/Herpes	Y N
Stroke	Y N	Psychiatric Problems	Y N
Hip & Joint Replacement	Y N	Diabetes	Y N
Chronic Hepatitis	Y N	Tuberculosis (TB)	Y N
Anemia	Y N	Sickle Cell Disease	Y N
High/Low Blood Pressure	Y N	Asthma	Y N
Severe Headaches	Y N	Lung Problems	Y N
Epilepsy/Seizures/Fainting Spells	Y N	Respiratory Issues	Y N
		Sleep Apnea	Y N
Drug/Alcohol Abuse	Y N	Neurological Problems	Y N
Thyroid	Y N	Artificial Joints or Valves	Y N
Hemophilia/Abnormal Bleeding	Y N	Antiresorptive Bone	
Cancer/Chemotherapy/Radiation	Y N	Medications	

Doctor's Comments:____

____

Any other serious medical conditions:

Have you experienced any that are not listed above ❑ yes ❑ No

If yes, please list:____

____

Are you allergic to any of the following?

Penicillin	Y N	Tetracycline	Y N
Dental Anesthetics	Y N	Metals	Y N
Latex	Y N	Acrylics	Y N
Aspirin	Y N	Opioids like Codeine/Hydrocodone	Y N

Are you allergic to any other drugs? ❑ Yes ❑ No

If yes, please list:____

____

DENTAL HISTORY

Why have you come to the dentist today? ____

____

____

Are you currently in pain? ❑ Yes ❑ No

Do you experience stress or anxiety when you visit a dental office? ❑ Yes ❑ No

The approximate date of your last dental visit: ____________________

Have you ever experienced TMJ problems? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No
(TMJ is pain or discomfort in your jaw joints.)

Your current oral health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

General Dentist:

Name:____

Phone: ____

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

So that we may assure you and other patients of uninterrupted treatment it is necessary for all patients to accept a definite arrangement for the appointments. Once an appointment is made, please remember this time is reserved for you.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

AT LEAST 48 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY. OTHERWISE A CANCELLATION CHARGE OF $75.00 WILL BE MADE

____

PATIENT'S SIGNATURE DATE

Additional Notes: ____

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