MEDICAL HISTORY

Physician's Name_____ Phone Number (_____)_____
How would you describe you health?_____ Date of last physical_____/_____/_____
Have you been hospitalized or under a physician's care in the last two years?_____
Please list ALL medications and drugs you are taking:_____
_____
Have you ever had to take a pre-med for a dental procedure? _____If so?_____
Are you taking or have you ever taken medications for osteoporosis (Fosomax, Boniva, Actonel, Reclast)?
_____If so when?_____

Have you ever had an adverse reaction or allergies to the following?(Please circle if allergic) N/A _____

Aspirin	Valium	Tetracycline	Novocaine
Codeine	Iodine	Penicillin	Xylocaine
Latex	Sulfa Drugs	Erythromycin	Other: _____

Have you ever had any of the following? (Please circle all that apply) N/A _____

Heart trouble	Dizziness or Fainting	Hepatitis (Type:)	HIV-AIDS-ARC
High/ Low Blood Pressure	Diabetes	Cancer	Venereal disease
Heart attack or stroke	Kidney or liver disease	Tumor or growth	Cold sores
Heart murmur	Ulcers or G.I. problems	X-ray/ Chemo therapy	Fever blisters
Rheumatic fever	Thyroid problems	Arthritis or gout	Herpes
Congenital heart problem	Asthma or allergies	Jaw joint pain	Bruise easily
Heart valve or pacemaker	Sinus problems	Glaucoma	Frequent thirst
Bleeding problem	Emphysema	Epilepsy or seizures	Frequent urination
Blood disease	Lung disease	Hypoglycemia	Use tobacco
Blood transfusion	Tuberculosis	Drug/ alcohol addiction	Now pregnant
Artificial joint:_____	Psychiatric	Eating disorder	Surgery:_____

Do you have any conditions or problems not listed about which we should know about? Please explain:
_____

DENTAL HISTORY

What are your present dental concerns? _____
When did you last see a dentist? _____
Have you avoided regular dental care? **Yes/ No** Why?_____
Do you feel you have cavities? **Yes/ No** Do you feel you have gum disease? **Yes/ No**
Have you ever had periodontal (gum) treatments? **Yes/ No**
How often do you brush? _____ Floss? _____ Use other cleaning aids? _____
Are you happy with the appearance of your teeth? **Yes/ No** Would you like your teeth to be whiter? **Yes/ No**
What are your dental expectations? _____

Do you currently have problems with any of the following? (Please circle those that apply)

Bleeding gums	Missing teeth	Grinding or clenching	Hot/ Cold Sensitivity
Bad breath	Pain when chewing	Sore areas in mouth	Sweet Sensitivity
Unpleasant taste	Jaw(s) clicking or popping	Frequent fillings breaking	Other_____
Loose/ Chipped tooth	Headaches or neck pain	Teeth sensitive to pressure	

Previous dentist? _____ City_____ State_____
Would you like to request your records from your previous dentist? **Yes/ No** Date of last cleaning? _____
My previous dental experience has been: _____ Positive _____ Neutral _____ Negative

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Home# _____ Cell#_____
Address_____ City_____ State _____ Zip _____