Please fill out the following information and sign at the bottom of the back page

HEALTH DATA (confidential)

PATIENT NAME _____ **D.O.B.** _____/_____/_____
mo date yr

MEDICAL HISTORY
(PLEASE ANSWER EACH QUESTION CHECK YES OR NO. IF IN DOUBT, LEAVE BLANK)

1. Reason for dental visit? _____

	YES	NO
2. Are you in good health now?…….	☐	☐
3. Are you now under the care of a physician?……..	☐	☐
If so, what is the condition being treated? _____		
4. Have you ever been hospitalized or had a serious illness?…….	☐	☐
If yes explain: _____		
5. Have you ever had excessive bleeding following an extraction or do cuts take longer to heal now than previously? …	☐	☐
6. (Women) Are you or maybe pregnant? If so, due date_____…..……...	☐	☐
7. Do you smoke or use any tobacco products? If so, amount_____……	☐	☐
8. Do you use alcoholic beverages? (More that 2 drinks per day) …….	☐	☐

9. Have you ever had or experienced any of the following (please answer questions below)

GENERAL	YES	NO
Tire easily, weakness……	☐	☐
Marked weight change….	☐	☐
Night sweats……..	☐	☐
Persistent Fever……	☐	☐
SKIN		
Eruptions (rash) hives….	☐	☐
Change in skin color……	☐	☐
EYES		
Visual change……...	☐	☐
Glaucoma…….	☐	☐
EARS		
Loss of hearing…….	☐	☐
Ringing in ears…….	☐	☐
NOSE		
Frequent nose bleeds……	☐	☐
Sinus problems…….	☐	☐
THROAT		
Soreness/ hoarseness …...	☐	☐
NERVOUS SYSTEM		
Stroke……	☐	☐
Headaches…….	☐	☐
Epilepsy/Convulsions…...	☐	☐
Numbness/ tingling ……..	☐	☐
Dizziness/ fainting……	☐	☐
Psychiatric treatment …...	☐	☐

RESPIRATORY	YES	NO
Tuberculosis…….	☐	☐
Emphysema…….	☐	☐
Asthma/ hay fever……	☐	☐
Persistent cough……...	☐	☐
Sputum production ……	☐	☐
Cough up bloody sputum….	☐	☐
Difficulty breathing while lying down……	☐	☐
HEART/ BLOOD VESSELS		
Rheumatic Fever……..	☐	☐
Heart murmur……...	☐	☐
Chest pain/ discomfort…….	☐	☐
Heart attack/ trouble…….	☐	☐
Shortness of breath……...	☐	☐
Swelling of ankles……	☐	☐
High blood pressure…….	☐	☐
Congenital heart disease…..	☐	☐
Artificial heart valve……	☐	☐
Pacemaker……	☐	☐
Other……	☐	☐
ENDOCRINE		
Diabetes……	☐	☐
Family history of diabetes…	☐	☐
Thyroid condition/ goiter….	☐	☐
Other……	☐	☐
BONE/MUSCLES		
Arthritis/Rheumatism……..	☐	☐
Artificial joints…….	☐	☐

DIGESTIVE SYSTEM	YES	NO
Hepatitis……	☐	☐
Jaundice (yellow)……..	☐	☐
Ulcers……	☐	☐
Eating Disorders……..	☐	☐
Frequent Vomiting……	☐	☐
Bloody/ brown vomitus	☐	☐
Black, bloody stools….	☐	☐
Frequent diarrhea…….	☐	☐
URINARY		
Kidney disease……..	☐	☐
Frequent urine (night)...	☐	☐
Blood in urine……...	☐	☐
Burning on urination….	☐	☐
Urethral discharge…….	☐	☐
Venereal disease……..	☐	☐
Syphilis…….	☐	☐
BLOOD		
Bleeding tendency…….	☐	☐
Bruise easily…….	☐	☐
Anemia…….	☐	☐
Blood transfusions……	☐	☐
HIV+/AIDS……..	☐	☐
OTHER		
Chemo therapy……..	☐	☐
Radiation therapy…….	☐	☐
Tumors or growths……	☐	☐
Cancer……...	☐	☐
Fen-Phen……...	☐	☐

CONTINUE ON THE BACK PAGE

10. Are you ALLERGIC or have ever experienced any reaction to the following?

	YES	NO		YES	NO		YES	NO
Local anesthetics (Novocaine)…	☐	☐	Penicillin……..	☐	☐	Aspirin……..	☐	☐
Barbiturates /sedatives ……...	☐	☐	Other antibiotics_____	☐	☐	Sulfa drugs……	☐	☐
Sleeping pills …….	☐	☐	Codeine…….	☐	☐	Other_____ ……	☐	☐

11. Have you taken any of the following medications within the last 3 months:

	YES	NO		YES	NO		YES	NO
Antibiotics/sulfa drugs……	☐	☐	Recreational drugs ……	☐	☐	Heart medications…….	☐	☐
Blood Thinners……	☐	☐	Thyroid medicine……..	☐	☐	Cortisone/Steroids……	☐	☐
Tranquilizers……...	☐	☐	Nitroglycerin…….	☐	☐	Diabetes drugs …….	☐	☐
Blood pressure medication..…...	☐	☐	Antihistamines/allergy			Birth Control Pills……	☐	☐
Aspirin…….	☐	☐	drugs/cold remedies …	☐	☐	Other _____	☐	☐

If YES to any of the above, list names of medication and dosage below:

Name	Dosage	Name	Dosage
1. _____		**4.** _____	
2. _____		**5.** _____	
3. _____		**6.** _____	

12. Is there any disease, condition or problem not listed above that you think we should know about or is there any activity your doctor says you cannot do?…….. YES ☐ NO ☐
If so, explain_____

13. Name and address of your (Medical Doctor)_____ Physician's Phone #_____

DENTAL HISTORY

	YES	NO
1. Do you like your smile?…….....	☐	☐
2. Would you like to change the appearance of your teeth?……..	☐	☐
3. Have you had ortho treatment (braces)?..…….	☐	☐
4. Have you had wisdom teeth extractions?……...……...	☐	☐
5. Have you ever been treated for periodontal disease (gum disease, scaling root planning, pyorrhea, trench mouth)?…….	☐	☐
6. Have you had any serious trouble associated with any previous dental treatment?…….……	☐	☐

If so explain_____

7. Does dental treatment make you nervous? None_____ Lightly _____ Moderate_____ Extremely_____

8. Date of last dental visit_____ Last Dental x-rays_____

Have you had any of the following?

MOUTH	YES	NO	TEETH	YES	NO	ORAL HYGIENE	YES	NO
Bleeding, sore gums……...	☐	☐	Loose teeth……..	☐	☐	Brush…….	☐	☐
Unpleasant taste/bad breath……...	☐	☐	Sensitive to hot……	☐	☐	How often _____		
Burning tongue/lips……	☐	☐	Sensitive to cold……..	☐	☐	Duration (mins) _____		
Frequent blisters, lips…….	☐	☐	Sensitive to biting……..	☐	☐	Dental Floss……..	☐	☐
Swelling/lumps in mouth……...	☐	☐	Sensitive to sweets …….	☐	☐	Water Flosser……	☐	☐
Biting Cheeks/lips……..	☐	☐	Food impaction……...	☐	☐	Tongue Scraper…….	☐	☐
Clicking/popping jaw……	☐	☐	Clenching./Grinding……	☐	☐	Fluoride rinse……	☐	☐
Difficulty opening/closing jaw……..	☐	☐	Shifting of teeth……...	☐	☐	Desensitize toothpaste..	☐	☐
Pain (jaw, ear, side of face)……..	☐	☐	Change in bite……	☐	☐	Other_____	☐	☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify my dentist of any changes in my health or medication.

Signature of Patient, Parent, or Guardian | **Parent or Guardian-Print name** | **Dr. Signature** | **Date**