MEDICAL HISTORY

Patient Name____

Physician____

Address ____ Phone______________________

Pharmacy Preferred____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hemophilia	Scarlet Fever
Alzheimer's Disease	Drug Addiction	Hepatitis/Liver problems	Shingles
HIV/Aids	Rheumatic Fever	Acid Reflux	
Anemia	Easily Winded	Hepatitis A, B or C	Sickle Cell Anemia
Angina	Dizziness/Fainting Spells	Herpes	Sinus Trouble
Arthritis/Gout	Easily Winded	High Blood Pressure	Spina Bifida
Artificial Heart Valve	Emphysema	Hives or Rash	Stomach/Intestinal Disease
Artificial Joint	Epilepsy	Hypoglycemia	Stroke
Asthma or Hay fever	Excessive Bleeding	Irregular Heartbeat	Swelling of Limbs
Blood Disease	Excessive Thirst	Kidney Problems	Thyroid Disease
Blood Transfusion	Frequent Cough	Leukemia	Tonsillitis
Bone Disorder	Frequent Diarrhea	Liver Disease	Tuberculosis
Breathing Problems	Frequent Headache	Low Blood Pressure	Tumors or Growths
Bruise Easily	Gastrointestinal Disorders	Lung Disease	Ulcers
Cancer/Chemotherapy	Genital Herpes	Mitral Valve Prolapse	Venereal Disease
Chest Pains	Glaucoma	Parathyroid Disease	Jaundice
Cold Sores/Fever Blisters	Heart Attack/ Failure	Psychiatric Care	
Convulsions	Heart Problems	Radiation Treatments	
Congenital Heart Defect	Heart Pace Maker	Recent Weight Loss	
Cortisone Medications	Heart Murmur	Renal Dialysis	

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ____

____

Yes No Are you allergic to any medication? ____

Yes No Are you allergic or have reactions to local anesthetics?________________________________

Yes No Do you have a Latex allergy?____

Yes No Do you have a history of a major illness? ____

Yes No Have you had any operations? ____

Yes No Have you ever had a serious head or neck injury? ____

Yes No Have you ever been involved in a serious accident? ____

Yes No Have seen a physician in the last 12 months? Why? ____

DENTAL HISTORY

Previous Dentist____Date of last visit_________________________

What concerns you most about your teeth? ____

Yes No Are you presently in any dental pain? ____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _______________________________

Yes No Have you ever lost or chipped any teeth? ____

Yes No Have there been any injuries to face, mouth, or teeth? _______________________________________

Yes No Is any part of your mouth sensitive to temperature? Where? ___________________________________

Yes No Is any part of your mouth sensitive to pressure? Where? _____________________________________

Yes No Do your gums bleed when you brush? ____

Yes No Do you have any type of thumb or tongue habit? ____

Yes No Are you a mouth breather? ____

Yes No Have you ever seen an orthodontist? If yes, who and when? ___________________________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?__________________

Yes No Are you aware of your jaw clicking or popping? ____

Yes No Are you aware of clenching your teeth during the day? ____

Yes No Have you ever been told that you grind your teeth? ____

Yes No Do you have “tension” headaches?____

Yes No Have you ever experienced chronic ringing in your ears?_______________________________________

Female Patients only:

Yes No Are you pregnant?____

Yes No Are you currently taking oral contraceptives?____

Signature: ____Date: ____________________

(Guardian Signature if under 18 years)