Patient Name: **Date:**

Medical Health Information

Have you been under the care of a medical doctor during the past two years? YES NO

If yes, for what?

Physician's Name: Phone:

Address:

Are you currently taking any medication, drugs, or pills now? YES NO

List all medications and "over the counter" medication/supplements:

Are you aware of having an allergic (or adverse reaction) to any medication or substance? YES NO

List:

Have you been a patient in the hospital during the past five years? YES NO

List:

Indicate which of the following you HAVE HAD in the past or HAVE presently Circle YES or NO

HEART (DISEASE, ATTACK)	**YES**	**NO**	ULCERS	**YES**	**NO**	HEPATITIS A B	**YES**	**NO**
CHEST PAIN	**YES**	**NO**	DIABETES	**YES**	**NO**	VENEREAL DISEASE	**YES**	**NO**
CONGENTAL HEART DISEASE	**YES**	**NO**	THYROID PROBLEM	**YES**	**NO**	A.I.D.S.	**YES**	**NO**
HEART MURMUR	**YES**	**NO**	GLAUCOMA	**YES**	**NO**	H.I.V.	**YES**	**NO**
MITRAL VALVE PROLAPSE	**YES**	**NO**	CONTACT LENSES	**YES**	**NO**	COLD SORES	**YES**	**NO**
ARTIFICIAL VALVE/STENT	**YES**	**NO**	EMPHYSEMA	**YES**	**NO**	BLOOD TRANSFUSION	**YES**	**NO**
PACEMAKER	**YES**	**NO**	CHRONIC COUGH	**YES**	**NO**	HEMOPHILIA	**YES**	**NO**
HIGH BLOOD PRESSURE	**YES**	**NO**	TUBERCULOSIS	**YES**	**NO**	SICKLE CELL	**YES**	**NO**
ARTHRITIS	**YES**	**NO**	ASTHMA	**YES**	**NO**	BRUISE EASILY	**YES**	**NO**
RHEUMATIC FEVER	**YES**	**NO**	HAY FEVER	**YES**	**NO**	LIVER DISEASE	**YES**	**NO**
CORTISONE MEDICINE	**YES**	**NO**	LATEX ALLERGY	**YES**	**NO**	YELLOW JAUNDICE	**YES**	**NO**
SWOLLEN ANKLES	**YES**	**NO**	ALLERGIES/HIVES	**YES**	**NO**	NEUROLOGIC(DISORDER)	**YES**	**NO**
STROKE	**YES**	**NO**	SINUS PROBLEMS	**YES**	**NO**	SEIZURES/EPILEPSY	**YES**	**NO**
DIET (SPECIAL OR RESTRICTED)	**YES**	**NO**	CHEMOTHERAPY	**YES**	**NO**	FAINTING	**YES**	**NO**
ARTIFICIAL JOINT	**YES**	**NO**	RADIATION	**YES**	**NO**	ANXIETY/NERVOUS	**YES**	**NO**
KIDNEY PROBLEMS	**YES**	**NO**	TUMORS	**YES**	**NO**	PSYCHOLOGIC CARE	**YES**	**NO**

Do you have or have you had any disease, condition, or problem not listed above? YES NO

If yes, list

Do you have difficulty being reclined? YES NO

WOMEN

PREGNANT: YES____months NO **NURSING**: YES NO **BIRTH CONTROL PILLS**: YES NO

Dental History and Information
~on the back side →

Dental History and Information

What is the reason for your visit today? ______

Do you have any dental problems at this time? ______

If yes, please describe: ______

______

Date of last dental visit: ______ Date of last dental cleaning: ______

Previous Dentist's name: ______

Address: ______

Phone: ______

How often do you brush your teeth? ______ How often do you floss? ______

What other dental aids do you use (toothpick, proxy-brush, etc)? ______

Do you currently use an electric or rotary toothbrush? ______

Do you have sensitivity to any of the following conditions? (Please circle all that apply)

HOT COLD SWEETS BITING CHEWING BRUSHING

Question		
Have you noticed any mouth odors or a bad taste in your mouth?	**YES**	**NO**
Do you frequently get cold sores, fever blister, or any other oral lesions?	**YES**	**NO**
Does food tend to become caught in between your teeth?	**YES**	**NO**
Do your gums bleed when you are brushing?	**YES**	**NO**
Have you noticed any loose teeth or change in your bite?	**YES**	**NO**
Have your parents experienced gum disease or tooth loss?	**YES**	**NO**
Do you bite your lips or checks frequently?	**YES**	**NO**
Have you ever had a serious injury to the mouth or head?	**YES**	**NO**
Do you smoke or chew tobacco?	**YES**	**NO**

Do you experience the following?

Condition		
Clench or grind your teeth while awake or sleeping	**YES**	**NO**
Clicking or popping of the jaw	**YES**	**NO**
Pain (joint, ear, side of face)	**YES**	**NO**
Difficulty in opening or closing the mouth	**YES**	**NO**
Headaches, neck aches, or shoulder aches	**YES**	**NO**
Sore muscles (neck, shoulders)	**YES**	**NO**

Have you ever had?

Treatment		
Orthodontic treatment	**YES**	**NO**
Periodontal treatment	**YES**	**NO**
Oral surgery	**YES**	**NO**
Bite or mouth guard	**YES**	**NO**

Do you feel nervous about having dental treatment? ______ YES NO

If so, what is your biggest concern? ______

Have you ever had an upsetting dental experience? ______ YES NO

If yes, please describe: ______

Consent: I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I authorize the dentist to perform diagnostic procedures, treatment, and to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who many release such information to you. I will notify the doctor of any change in my health or medications.

O.K. to release information to ______ **Relationship to patient** ______

Patient/Guardian Signature: ______ **Date:** ______