

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking could have an important inter-relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under physicians care now? No Yes Explain: _____
Have you ever been hospitalized or had a major operation? No Yes _____
Have you ever had a serious head or neck injury? No Yes _____
Do you take or have you taken Biophosphonates, Fosomax, Aredia, Zometa, Ortonel or Boniva? (Circle any that apply) No Yes
Are you on a special diet? _____
Do you use controlled substances? No Yes Do you use Tobacco? No Yes
Are you taking any medications, pills or drugs? Please list: _____

Do you have any allergies? No Yes Please list: _____

Do you have or have you had any of the following?

**Condition may require medication*

- | | | |
|--|--|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Recent weight loss |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rhumatism |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hemophillia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Stomach/IntestineDisease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse* | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pain in Jaw Joints | |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date _____

Dental History

Date of last Dental Exam? _____

Are you having any dental discomfort at this time?.....Yes No

Do you feel nervous about having dental treatment?.....Yes No

Are your teeth sensitive to hot or cold?.....Yes No

Are you interested in Whitening your smile?.....Yes No

Do you have clicking or popping in your jaw or TMJ?.....Yes No

Would you like to change anything about your smile? _____
