



## Dental and Medical History

Are you currently under the care of a physician?  Yes  No If Yes, for what reason? \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_  
History of major illness?  Yes  No If Yes, please describe \_\_\_\_\_  
Currently taking any medications?  Yes  No If Yes, please list \_\_\_\_\_ Amount/Dose \_\_\_\_\_  
Are you required to take antibiotics before dental treatment?  Yes  No If Yes, explain \_\_\_\_\_  
Have you ever had a serious / difficult problem associated with any previous dental work?  Yes  No  
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?  Yes  No  
Your current dental health is:  Good  Fair  Poor Do you have any missing or extra permanent teeth?  Yes  No  
Do you like your smile?  Yes  No Do your gums bleed?  Yes  No  
Have you ever had an injury to your:  Mouth  Teeth  Chin  
Do you have any speech problems?  Yes  No If Yes, please describe \_\_\_\_\_  
Do you generally breathe through your mouth? Awake?  Yes  No Asleep?  Yes  No

### Check ( ✓ ) if you ever had any of the following diseases or medical problems:

- |  |   |
|--|---|
| <input type="checkbox"/> Anemia / Radiation Treatment      | <input type="checkbox"/> Heart Surgery / Pacemaker      |
| <input type="checkbox"/> Artificial Bones / Joints         | <input type="checkbox"/> Hemophilia / Abnormal Bleeding |
| <input type="checkbox"/> Artificial Valves                 | <input type="checkbox"/> Hepatitis                      |
| <input type="checkbox"/> Asthma / Arthritis                | <input type="checkbox"/> High / Low Blood Pressure      |
| <input type="checkbox"/> Blood Transfusion                 | <input type="checkbox"/> HIV positive / AIDS            |
| <input type="checkbox"/> Cancer / Chemotherapy             | <input type="checkbox"/> Hospitalized for any reason    |
| <input type="checkbox"/> Congenital Heart Defect           | <input type="checkbox"/> Kidney / Liver Problems        |
| <input type="checkbox"/> Diabetes / Tuberculosis (TB)      | <input type="checkbox"/> Mitral Valve Prolapse          |
| <input type="checkbox"/> Difficulty Breathing              | <input type="checkbox"/> Psychiatric Problems           |
| <input type="checkbox"/> Drug / Alcohol Abuse              | <input type="checkbox"/> Rheumatic / Scarlet Fever      |
| <input type="checkbox"/> Emphysema / Glaucoma              | <input type="checkbox"/> Severe / Frequent Headaches    |
| <input type="checkbox"/> Epilepsy/Seizures/Fainting Spells | <input type="checkbox"/> Shingles                       |
| <input type="checkbox"/> Fever Blisters / Herpes           | <input type="checkbox"/> Sinus Problems                 |
| <input type="checkbox"/> Heart Attack / Stroke             | <input type="checkbox"/> Ulcers / Colitis               |
| <input type="checkbox"/> Heart Murmur                      | <input type="checkbox"/> Venereal Disease               |

### Check ( ✓ ) if you are allergic to any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Dental Anesthetics |
| <input type="checkbox"/> Any Metal / Plastic  | <input type="checkbox"/> Erythromycin       |
| <input type="checkbox"/> Latex  | <input type="checkbox"/> Penicillin         |
| <input type="checkbox"/> Codeine  | <input type="checkbox"/> Tetracycline       |
| <input type="checkbox"/> Other, Please list any other drugs that you are allergic to: _____ |   |
| _____   |   |
| _____   |   |

### For Women:

Are you taking birth control pills?  Yes  No  
Are you pregnant?  Yes  No Week # \_\_\_\_\_  
Are you nursing?  Yes  No

## Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials \_\_\_\_\_ Date \_\_\_\_\_

### Doctor's Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_