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

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

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?_____

_____

Submit