# Medical History

Physician's Name: _____ Telephone: _____ Last Visit: _____

Are you under the care of a physician? □ Yes □ No Please explain:_____
Are you taking any medications or drugs? □ Yes □ No Please List:_____
Have you been hospitalized in the last 5 years? □ Yes □ No Please explain: _____

**ARE YOU ALLERGIC TO OR HAVE HAD AN ADVERSE REACTION TO:**

□ Penicillin □ Erythromycin □ Codeine □ Sulfa □ Advil/Motrin □ Iodine □ Latex
□ Tetracycline □ Local Anesthetics □ Barbiturates □ Aspirin □ Other: _____ Yes / No

**Check if you have or ever had…**

| | | |
|---|---|---|
| □ Yes □ No AIDS/HIV | □ Yes □ No Emphysema | □ Yes □ No Nervous Problem |
| □ Yes □ No Anemia | □ Yes □ No Epilepsy | □ Yes □ No Pacemaker |
| □ Yes □ No Arthritis/Rheumatism | □ Yes □ No Fainting/Dizziness | □ Yes □ No Psychiatric Care |
| □ Yes □ No Artificial Heart Valves | □ Yes □ No Glaucoma | □ Yes □ No Radiation Treatment |
| □ Yes □ No Artificial Joints | □ Yes □ No Headaches | □ Yes □ No Respiratory Disease |
| □ Yes □ No Asthma | □ Yes □ No Heart Murmur | □ Yes □ No Rheumatic Fever |
| □ Yes □ No Back Problems | □ Yes □ No Heart Problems | □ Yes □ No Shortness of Breath |
| □ Yes □ No Excessive Bleeding | □ Yes □ No Hepatitis | □ Yes □ No Sinus Trouble |
| □ Yes □ No Blood Disease | □ Yes □ No Herpes | □ Yes □ No Stroke |
| □ Yes □ No Cancer | □ Yes □ No High Blood Pressure | □ Yes □ No Swollen Feet/Ankles |
| □ Yes □ No Chemical Dependency | □ Yes □ No Jaundice | □ Yes □ No Thyroid Problems |
| □ Yes □ No Chemotherapy | □ Yes □ No Jaw Pain | □ Yes □ No Tonsillitis |
| □ Yes □ No Circulatory Problems | □ Yes □ No Kidney Disease | □ Yes □ No Tuberculosis |
| □ Yes □ No Congenital Heart Lesions | □ Yes □ No Liver Disease | □ Yes □ No Tumor on Head/Neck |
| □ Yes □ No Cortisone Treatments | □ Yes □ No Low Blood Pressure | □ Yes □ No Ulcer |
| □ Yes □ No Diabetes | □ Yes □ No Mitral Valve Prolapses | □ Yes □ No Venereal Disease |

Please list any other disease/condition you may have: _____

**Women:** Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No Taking birth control pills? □ Yes □ No
I am aware that when on antibiotics therapy, my birth control may not be effective. _____ Initials

# Dental History

Purpose of Today's Visit: _____ Former Dentist: _____
Last Visit: _____ How often do you: Brush?: _____ Floss?: _____
Have you ever had: □ Orthodontics □ Gum Treatment □ Root Canal □ Implants □ Crowns
Are you happy with the appearance of you teeth? □ Yes □ No

**Check if you have or ever had…**

| | | |
|---|---|---|
| □ Yes □ No Bad Breath | □ Yes □ No Fingernail biting | □ Yes □ No Pain around ear |
| □ Yes □ No Bleeding gums | □ Yes □ No Grinding teeth | □ Yes □ No Sensitivity to cold |
| □ Yes □ No Blisters on lips/mouth | □ Yes □ No Gums swollen | □ Yes □ No Sensitivity to hot |
| □ Yes □ No Broken fillings | □ Yes □ No Jaw pain/tiredness | □ Yes □ No Sensitivity to sweets |
| □ Yes □ No Burning | □ Yes □ No Lip/cheek biting | □ Yes □ No Smoking |
| □ Yes □ No Clicking jaw | □ Yes □ No Loose teeth | |
| □ Yes □ No Dry mouth | □ Yes □ No Mouth breathing | |

***I CERTIFY THAT ALL THE INFORMATION STATED ON THIS FORM IS CORRECT. I ALSO UNDERSTAND THAT THE DENTIST IS NOT RESPONSIBLE FOR ANY ACTION TAKEN OR NOT TAKEN DUE TO ERRORS WHEN FILLING OUT THIS FORM.***

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient/Responsible Party | Signature of Doctor | Date |