

LAST NAME _____ FIRST NAME _____ DATE _____

DATE OF BIRTH _____ SEX _____

MEDICAL HEALTH HISTORY

GENERAL HEALTH (Please check): Excellent Good Fair Poor

PHYSICIAN: _____ DATE OF LAST EXAM: _____

ADDRESS: _____ If exam, for what reason? _____

PHONE: _____

ARE YOU TAKING ANY MEDICATION NOW? Yes No

If yes, list all medications you are taking and for what purpose. _____

HAVE YOU EVER BEEN PREMEDICATED WITH ANTIBIOTICS FOR DENTAL TREATMENT? Yes No

IF YES, FOR WHAT REASON? _____

ARE YOU ALLERGIC TO (Please check):

- Penicillin
- Codeine
- Antibiotics
- Local Anesthetics (such as Novocaine)
- Aspirin
- Latex Allergy

ALLERGIC TO ANY OTHER MEDICATIONS? _____

ARE YOU CURRENTLY TAKING ANY DRUGS OTHER THAN FOR MEDICINAL PURPOSES? IF SO, WHAT? _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAVE HAD SURGERY? If so, give name of hospital, reason and dates.

HOSPITAL: _____ REASON: _____ DATE: _____

HOSPITAL: _____ REASON: _____ DATE: _____

Have you had any medical diagnostic x-rays in the last five years? Yes No

Have you had any dental diagnostic x-rays in the last five years? Yes No

Have you had any blood transfusions? Yes No

Are you currently trying to modify your weight? Yes No

Do you take any medications to help in weight reduction? Yes No

Do you use tobacco products? Yes No If yes, type _____ How many per day? _____

Do you consume alcohol on a daily basis? Yes No

Is your blood pressure: NORMAL LOW HIGH NOT KNOWN

Have you experienced any recent weight change? Yes No

WOMEN: Are you pregnant? Yes No HOW LONG? _____

Do you experience pre-menstrual syndrome? Yes No

Do you wear contact lenses? Yes No

DO YOU PRESENTLY HAVE OR HAD IN PAST? (Please check)

- Thyroid Problems
- Hormonal Problems
- Ulcers
- Tuberculosis or Lung Disease
- Diabetes
- Epilepsy or Seizures
- Anemia
- Postural Hypotension (Fainting Spells)
- Hypertension
- Kidney Problems
- Chest Pains
- Heart Disease (and/or Pacemaker/Stint/Shunt/etc.)
- Stroke
- Rheumatic Fever
- Congenital Heart Defects
- Heart Murmur
- Mitral Valve Prolapse
- Joint Replacement (Knee/Hip/etc. with Metal Screws/Plates/etc.)
- Implants (Type) _____
- Organ Transplants (Type) _____

(Continued on Back)

DO YOU PRESENTLY HAVE OR HAD IN PAST? (Please check)

- | | |
|--|---|
| <input type="checkbox"/> Cancer or Leukemia | <input type="checkbox"/> Prolonged Bleeding Problems |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Sexually transmitted diseases: (Gonorrhea, Syphilis, Genital Herpes) |
| <input type="checkbox"/> Clinical Depression | <input type="checkbox"/> Genetic Abnormalities |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Skin Diseases |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> AIDS/HIV Positive |
| <input type="checkbox"/> Prosthetic Valves or Joints | <input type="checkbox"/> Unexplained Fevers |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Prolonged Sore Throat |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Enlarged Lymph Nodes |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Persistent Diarrhea |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Bluish-Reddish Lesions |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Excessive Urination and/or Thirst | <input type="checkbox"/> Persistent Cough |

Have you ever been treated for HEPATITIS? If yes, TYPE: _____ DATE: _____ YES NO

Do you have a history of cold sores, fever blisters or canker sores? YES NO

Are you being treated with immunosuppressive drugs? YES NO

DENTAL HEALTH HISTORY

Date of last dental exam _____ Date of last dental cleaning _____

Have you ever had any serious problems associated with previous dental treatment?
 YES NO If yes, explain _____

How often do you brush your teeth? _____

How often do you floss? _____

Do you routinely use a mouth rinse? YES NO HOW OFTEN? _____

Do you experience dry mouth (Xerostomia)? YES NO

Do your gums feel tender or swollen? YES NO

Do your gums bleed while brushing and/or flossing? YES NO

Do you avoid brushing any part of your mouth because of pain or sensitivity? YES NO

Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet or sour? YES NO

Are any of your teeth sensitive to air or during chewing? YES NO

What texture brush do you use? SOFT MEDIUM HARD

Do you chew on only one side of your mouth? YES NO

Does food catch between your teeth? YES NO

Do you feel your teeth are affecting your health in any way? YES NO

Have you ever had professional advice in dental home care? YES NO

Do you clench or grind your teeth while sleeping or during the day? YES NO

Do your facial muscles ever feel tired? YES NO

Do you wear full dentures? UPPER LOWER Do you wear partial dentures? UPPER LOWER

Do you have retention problems with your full or partial dentures? YES NO

Do you gag easily? YES NO

Are you apprehensive (nervous) about your dental treatment? YES NO

Have you had: NITROUS OXIDE MEDICATION PRIOR TO TREATMENT

Please add anything you feel is important: _____

CONSENT

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

 PATIENT'S SIGNATURE (Or Responsible Party's Signature if patient is under age 18) DATE