MEDICAL / DENTAL HISTORY

1. Primary Physician's Name _____
   Address/Phone _____
2. Are you under a physician's care? ☐ YES ☐ NO
   Since when_____ Why _____
3. Are you taking any medications or substances (incl. vitamins/herbs) ☐ YES ☐ NO
   (If yes, please list medications in section to the right)
4. Are you allergic to any medications or substances? ☐ YES ☐ NO
5. Do you have any other allergies? ☐ YES ☐ NO
6. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ☐ YES ☐ NO
7. Are you sensitive to any metals or latex? ☐ YES ☐ NO
8. Are you pregnant or suspect you may be? ☐ YES ☐ NO
9. Have you ever been treated for or been told you might have heart disease? ☐ YES ☐ NO
10. Do you have a pacemaker or an artificial heart valve implant? ☐ YES ☐ NO
11. Have you ever had rheumatic fever? ☐ YES ☐ NO
12. Are you aware of any heart murmurs? ☐ YES ☐ NO
13. Do you have high or low blood pressure? ☐ YES ☐ NO
14. Have you ever had a serious illness, major surgery or hospitalization? ☐ YES ☐ NO
15. Have you had a heart attack or stroke? ☐ YES ☐ NO
16. Have you ever had radiation treatment or chemo treatment for tumor, growth? ☐ YES ☐ NO
17. Have you been diagnosed or treated for cancer? ☐ YES ☐ NO
18. Do you have inflammatory diseases, such as arthritis or rheumatism? ☐ YES ☐ NO
19. Do you have any artificial joints / prosthesis / pins / implants? ☐ YES ☐ NO
20. Do you have any blood disorders, such as anemia, leukemia, etc? ☐ YES ☐ NO
21. Do you have any kidney / liver / stomach problems? ☐ YES ☐ NO
22. Are you diabetic? ☐ YES ☐ NO
23. Do you have asthma? ☐ YES ☐ NO
24. Do you have epilepsy or seizure disorders? ☐ YES ☐ NO
25. Do you or have you had a venereal disease? ☐ YES ☐ NO
26. Have you tested HIV positive or have AIDS? ☐ YES ☐ NO
27. Have you had or do you test positive for hepatitis / jaundice? ☐ YES ☐ NO
28. Do you or have you had T.B.? ☐ YES ☐ NO
29. Do you smoke, chew, use snuff or any other form of tobacco? ☐ YES ☐ NO
30. Do you have a history of drug or alcohol abuse? ☐ YES ☐ NO
31. Have you had psychiatric treatment? (Including depression or panic attacks) ☐ YES ☐ NO
32. Do you have any of the following: YES NO ☐ YES ☐ NO

	YES	NO		YES	NO
Growths, sores or swollen areas in your mouth.	☐	☐	Jaws click, crack, lock or pop	☐	☐
Bleeding gums	☐	☐	Clench or grind your teeth	☐	☐
Periodontal (gum) treatment	☐	☐	Any teeth sensitive to heat, cold or sweets	☐	☐
Bad breath	☐	☐	Pain in or near ear	☐	☐
Orthodontic Treatment	☐	☐			

33. Have you had any serious trouble associated with any previous dental treatment? ☐ YES ☐ NO
    If yes, explain: _____
34. Is there anything else we should know about your health that we have not covered in this form? _____
35. Are you having any dental discomfort at this time? ☐ YES ☐ NO
36. Chief dental complaint:_____
37. Date of last dental visit: _____

MEDICATIONS

If more room is needed please attach a copy of your medications

If you answered YES to any of the questions please elaborate as needed in the space provided below

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE_____ DATE _____

DENTIST'S SIGNATURE_____ DATE _____