Patient Name: _____ **Parent or Legal Guardian Name:** _____

MEDICAL HISTORY

Do you have or have you had any of the following?
(please check all that apply)

☐ **1)** heart attack, heart murmur, heart surgery, or pains in your chest
☐ **2)** rheumatic fever, prosthetic heart valve, or a joint replacement
☐ **3)** cancer or tumor
☐ **4)** chemotherapy, radiation, radium or cobalt treatment
☐ **5)** injury to your face or jaw
☐ **6)** eye problems (cataracts or glaucoma)
☐ **7)** earaches, ringing in your ears or loss of hearing
☐ **8)** sinus trouble, asthma, hay fever or severe headaches
☐ **9)** frequent sore throats or neck pain
☐ **10)** high or low blood pressure
☐ **11)** a stroke or been told you have hardening of the arteries
☐ **12)** pacemaker
☐ **13)** shortness of breath with mild exercise
☐ **14)** tuberculosis, emphysema or any other lung problem
☐ **15)** stomach or intestinal tract problems (ulcers, gastritis or colitis)
☐ **16)** liver condition (hepatitis, jaundice or cirrhosis)
☐ **17)** kidney or bladder problems
☐ **18)** AIDs, HIV virus, or any other STD
☐ **19)** aphthous ulcers, canker or cold sores, or herpes
☐ **20)** diabetes
☐ **21)** thyroid or adrenal disease
☐ **22)** seizures or convulsive disorders
☐ **23)** tendency to bleed longer than normal from small cuts
☐ **24)** blood disorder (anemia, leukemia or sickle cell anemia)
☐ **25)** blood transfusion
☐ **26)** skin rashes or severe itching
☐ **27)** hospitalized, surgery or serious medical condition (list on back)
☐ **28)** any disease/condition not listed above _____

☐ **29)** Do you use tobacco?
☐ **30)** Do you consume alcoholic beverages?
☐ **31)** Women only: Are you pregnant?

Do you have any allergies or adverse reactions to any of the following?
☐ penicillin or other antibiotics
☐ anesthetic
☐ latex
☐ asprin
☐ foods
☐ anything not listed above _____

Are you taking or have you taken any of the following?
☐ medication for nervousness or depression
☐ Fosomax, Boniva, Zometa, Actonel, Didronel, Reclast or any other bisphosphonate
☐ cortisone or other steroids
☐ anticoagulants or blood thinners
☐ tranquilizers
☐ any other drug or medication not listed above please list below
_____
_____
_____

Family history of diabetes, heart disease, tumors or cancer? Yes or No
_____
_____

Name of physician: _____
Office phone number: _____

DENTAL HISTORY

Do you or have you ever?

☐ **1)** experience stress or anxiety at dental appointment
☐ **2)** experience TMJ problems (pain or discomfort in your jaw joint)
☐ **3)** clench or grind your teeth
☐ **4)** been sedated or received antibiotics prior to dental treatment
☐ **5)** had any teeth extracted or tonsils removed
☐ **6)** had local anesthetic (Novocain) or general anesthetic (ether)
☐ **7)** any unusual stress at work or home
☐ **8)** spaces between teeth where there were none before
☐ **9)** teeth that feel loose
☐ **10)** experience bleeding gums
☐ **11)** been told you have periodontal disease
☐ **12)** experience sores or growths in your mouth
☐ **13)** have problems with bad breath on a regular basis
☐ **14)** had sealants
☐ **15)** been interested in teeth whitening
☐ **16)** been interested in bonding or veneers
☐ **17)** cosmetic dentistry that could improve your smile
☐ **18)** wear/worn dentures

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Doctor to perform the treatment/procedure/surgery that is deemed necessary to adequately achieve maximum oral health.

SIGNATURE (patient or legal guardian)**:** _____ **DATE:** _____

For Office Use Only:
1. Patients Intitials: _____ Date: _____ 2. Patients Intials: _____ Date: _____ 3. Patients Intials: _____ Date: _____