# MEDICAL INFORMATION

The answers you provide to the following questions will help us determine the proper treatment for you.
These records are kept confidential in our office.

**Patient Name:** ______________________________ **Birth Date:** ______________ **Age:** ______

| YES | NO | |
|---|---|---|
| ____ | ____ | Are you in good health? |
| ____ | ____ | Have there been any changes in your general health within the last year? |
| ____ | ____ | Are you now under the care of a Physician? If so, what for: ______________________________ ______________________________ ______________________________ |
| | | Name of Medical Doctor: ______________________________ |
| ____ | ____ | Have you had any serious illnesses, injuries or operations? Please list: ______________________________ ______________________________ ______________________________ ______________________________ |
| ____ | ____ | Have you ever stayed overnight in a hospital? |
| ____ | ____ | Have you had excessive bleeding from an extraction or previous surgery? |
| ____ | ____ | Do you bruise easily? |
| ____ | ____ | Have you ever required a blood transfusion? |
| ____ | ____ | Is there any reason to believe that your immune system may be compromised? |
| ____ | ____ | Do you have any blood disorders? |
| ____ | ____ | Are you currently taking any medications or drugs? Please list: ______________________________ ______________________________ ______________________________ |
| ____ | ____ | Do you have any organ transplants? |
| ____ | ____ | Have you ever had any radiation treatments or chemotherapy? |
| ____ | ____ | Have you had any serious trouble associated with previous dental treatment? If so, what? ______________________________ ______________________________ ______________________________ |
| ____ | ____ | Have you ever used Phen-Fen, even once? |
| ____ | ____ | Women: Are you pregnant? |
| ____ | ____ | Do you use smokeless tobacco? |
| ____ | ____ | Do you smoke? If so, how many packs per day: _______ |
| ____ | ____ | Does your jaw pop, click, or grind when you open? |
| ____ | ____ | Do you have any body piercings or tattoos? |

| YES | NO | **Do you have or have you ever had any of the following medical conditions:** |
|---|---|---|
| ____ | ____ | Rheumatic fever or rheumatic heart disease |
| ____ | ____ | Heart murmur |
| ____ | ____ | High or low blood pressure |
| ____ | ____ | Chest pains |
| ____ | ____ | Previous heart attack |
| ____ | ____ | Shortness of breath after mild exercise |
| ____ | ____ | Ankle swelling |
| ____ | ____ | Pacemaker or artificial valves |
| ____ | ____ | Bypass surgery |
| ____ | ____ | Asthma or hay fever |
| ____ | ____ | Hives or a skin rash |
| ____ | ____ | Fainting spells or seizures |
| ____ | ____ | Diabetic or blood sugar problems |
| ____ | ____ | Hepatitis, jaundice or liver disease |
| ____ | ____ | Arthritis |
| ____ | ____ | Stomach ulcers |
| ____ | ____ | Kidney disease |
| ____ | ____ | Tuberculosis |
| ____ | ____ | Venereal disease |
| ____ | ____ | Cancer |
| ____ | ____ | Glaucoma |
| ____ | ____ | Frequent headaches |
| ____ | ____ | Stroke |
| ____ | ____ | Scarlet fever |
| ____ | ____ | Anemia |
| ____ | ____ | Tumor or abnormal growth |
| ____ | ____ | Bleeding or clotting problems |
| ____ | ____ | Liver problems |
| ____ | ____ | Sinus problems |
| ____ | ____ | Lung problems |
| ____ | ____ | Persistent cough |
| ____ | ____ | Seasonal allergies |
| ____ | ____ | Thyroid problems |
| ____ | ____ | Epilepsy |
| ____ | ____ | Leukemia |
| ____ | ____ | Fibromyalgia |
| ____ | ____ | Prosthesis or artificial joint |
| ____ | ____ | HIV/AIDS |
| ____ | ____ | HPV |
| ____ | ____ | Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Please explain: ______________________________ |
| | | **Are you allergic to or ever had a reaction to:** |
| ____ | ____ | Dental anesthetics |
| ____ | ____ | Antibiotics |
| ____ | ____ | Latex |
| ____ | ____ | Medications: __________________________ |
| ____ | ____ | Are you on any other treatment or taking medications that could affect your dental treatment? (herbs, vitamins, etc.) Please list: ______________________________ |

## DENTAL HISTORY

1. What is your reason for this visit? ______________________________________________

2. Please describe any dental problem that is bothering you at this time:

_________________________________________________________________________

_________________________________________________________________________

3. When was your last visit to the dentist? _________ Reason for last visit ________________

4. Have you ever had or do you now have: (Please check all that apply)

- ❑ Problems with dental treatment
- ❑ Problems with anesthetics
- ❑ Pain in teeth or jaws
- ❑ Clenching or grinding of teeth
- ❑ Clicking or pain in jaw joint
- ❑ Headaches
- ❑ Injuries to your teeth or jaw
- ❑ Food catching between teeth
- ❑ Loose teeth
- ❑ Bleeding gums
- ❑ Periodontal Disease
- ❑ Dry mouth
- ❑ Snoring problem
- ❑ Orthodontics
- ❑ Sensitivity to sweets, biting
- ❑ Sensitivity to hot/cold
- ❑ Sensitivity to jewelry or metal
- ❑ Other: _________________

5. Do you have missing teeth?_____ If so, how have they been replaced?_________________

6. Do you gag easily? ______________

7. How often do you brush your teeth? ________________ Floss them? _________________

8. What type of toothpaste do you use? _______________ Mouthwash? ________________

9. How do you feel about the appearance of your smile? ______________________________

10. Have you ever had a bad experience in a dental office? _____ If yes, please explain:

_________________________________________________________________________

_________________________________________________________________________

11. Please add anything you feel is important for us to know about your health or dental history:

_________________________________________________________________________

_________________________________________________________________________

______________________________ ________________

Signature of patient or guardian Date

---

**FOR OFFICE USE**

Notes:___________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_____________________________________________________