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:** _____

Have there been any changes in your general health since we last saw you?

Are you currently under the care of a physician? If so, what for:

Name of physician:

Have you had any serious illnesses, injuries or operations? Please list:

Do you smoke? Y N How many packs per day:
Do you use smokeless tobacco? Y N What type and how often:
Do you have any organ transplants? Y N
Is there any reason to believe that your immune system may be compromised? Y N
Have you ever required a blood transfusion or kidney dialysis? Y N
Do you have any body piercings or tattoos? Y N
Women: Are you pregnant? Y N
Does your jaw pop, click or grind when you open? Y N

Please list ALL drugs and medications you are currently taking:

Are you allergic to any of the following?
☐ Antibiotics ☐ Latex ☐ Dental Anesthetics ☐ Other_____

Do you have, or have you had, any of following?

	YES		YES		YES
AIDS/HIV Positive		Hemophilia/Blood Disorder		Diabetes	
Hepatitis A		Hepatitis B or C		Anemia	
Easily Winded		Herpes		Rheumatic Heart Disease/Fever	
High Blood Pressure		Arthritis/Gout		Epilepsy or Seizures	
Scarlet Fever		Artificial Heart Valve		Hives or Rash	
Autoimmune Disorder		Artificial Joint/Prosthesis		Asthma/Hay Fever	
Fainting Spells/Dizziness		Sinus Trouble		Bleeding/Clotting Problems	
Persistent Cough		Kidney Disease		Leukemia	
Stomach/Intestinal Disease		Frequent Headaches		Stroke	
Bruise Easily		Swelling of Limbs		Cancer	
Glaucoma		Lung Disease		Thyroid Disease	
Chemotherapy/Radiation		Chest Pains		Heart Attack/Failure	
Tuberculosis		Cold Sores/Fever Blisters		Heart Murmur	
Tumors or Growths		Heart Pacemaker		Stomach Ulcers	
Venereal Disease		Liver Disease/Jaundice		HPV	
Seasonal Allergies		Low Blood Pressure		Bypass Surgery	

Do you have or have you ever had a serious illness not listed above?_____

Signature of Patient or Guardian _____ **Date** _____

DENTAL HISTORY

1. What is your reason for this visit? _____

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

   _____

   _____

3. May we contact your previous dentist? Y / N

4. Name/Address:_____Ph:_____

5. When was your last visit to the dentist? _____ Reason for last visit _____

6. 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: _____

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

8. Do you gag easily? _____

9. How often do you brush your teeth? _____ Floss them? _____

10. What type of toothpaste do you use? _____ Mouthwash? _____

11. How do you feel about the appearance of your smile? _____

12. Have you ever had any serious trouble associated with previous dental treatment? _____ If so, what?

    _____

    _____

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

    _____

    _____

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

    _____

    _____

Signature of Patient or Guardian _____ Date _____