



Medical/Dental History

Name _____ Date of Birth _____ Age _____
Address _____ Preferred or Nickname _____
City, State, Zip _____ Home Number _____
Email _____ Work Number _____
Physician's Name _____ Cell Number _____
Date of last visit _____ Phone Number _____
Have you had any serious illnesses or operations? Y N
If yes, describe _____
Are you currently under physician care? Y N If yes, describe _____
Emergency Contact/Phone: _____
Have you ever had a blood transfusion? Y N If yes, give approximate date: _____
Do you have any health problems that need further clarification? Yes No
If yes, explain: _____
Women: Are you pregnant Y N Nursing Y N Taking birth control pills? Y N

Check if you have had any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Fainting Tendency |
| <input type="checkbox"/> Heart Murmur/Trouble | <input type="checkbox"/> Cancer of Tumor | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney/Bladder Trouble | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Tobacco Habit |

Are you currently taking any medications? If yes, list all:

Do you have drug allergies? If yes, list all:

Check any of the following that you are taking *OR* have taken:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anticoagulants/Blood Thinners | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Cortisone Drugs | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Phen Phen/Redux |
| <input type="checkbox"/> Fosamax | | |

What would you like us to do today? _____

Date of last dental care? _____ Date of last x-rays _____

Have you ever had an adverse reaction during or in conjunction with a medical or dental procedure? Yes N

If yes, explain: _____

Other information about your dental health or previous treatment _____

Check if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Clicking or jaw popping | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growths in mouth |

The above information is true to the best of my knowledge:

Signature: _____ Date: _____