DENTAL/MEDICAL HISTORY

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A complete and accurate health history is essential for proper dental care

Name_____ Male Female
Physician's Name_____
Physician's Office Location_____ Phone No._____
Date of last complete physical exam_____

Please Circle "Yes" or "No"
*Are you currently in good health? Yes No
*Are you currently under medical treatment? Yes No
*Are you taking medications regularly? Yes No
If "yes", please list medications, dosage, and frequency_____
_____

Please Check any of the following which you have had or have at present.

__Congestive Heart Failure	__Anemia	__Thyroid Disease	__Jaundice
__Heart Disease or Attack	__Stroke	__Radiation Tx.	__Angina
__Kidney Problems or Disease	__Arthritis	__Venereal Disease	__HIV/AIDS
__Hypertension	__Ulcers	__Cancer	__Cold Sores
__Heart Murmur	__Emphysema	__Rheumatic Fever	__Cough
__Glaucoma	__Epilepsy/Seizures		__Asthma
__Congenital Heart Defect	__Scarlet Fever	__Psychiatric Disorder	__Diabetes
__Hepatitis A B C	__Artificial Joint	__Heart Surgery	__Tuberculosis

Other conditions/diseases not listed:_____

*Have you ever had an allergic reaction to local dental anesthetics or any other drugs used in the dental office? Yes No
*Have you had any excessive bleeding requiring special treatment? Yes No
*Do you ever experience chest pain or excessive shortness of breath with activity? Yes No
*Do you use more than two pillows to sleep? Yes No
*Do you have sleep apnea? Yes No
*Do you Smoke? Yes No Type_____Amount used per day_____
*Do you use any recreational drugs? Yes No Drugs used_____

WOMEN ONLY

Are you pregnant now? Yes No
Are you using oral contraceptives? Yes No

DENTAL HISTORY

Please check any conditions that you have noticed: __ Tenderness __ Sore Areas in mouth
__Pain in or near ears __Bleeding Gums __Bad Breath __Sensitivity to hot, cold, sweets
(Adults Only) Are you interested in using anxiety reducing medication for dental treatment? Yes No
Are you interested in Tooth Whitening? Yes No
Are you interested in Teeth Straightening with conventional braces or Invisalign? Yes No

Date of Last Dental Exam_____ Dentist Name/Location_____

(OVER)