MEDICAL HEALTH HISTORY

Patient Name:__________________________________Date:______/______/_______

Physician_________________ Office Phone______________

Do you require any pre-medication due to joint replacement surgery, specific heart conditions, or for any other reason? YES NO

1. Are you under medical treatment now? YES NO
2. Have you ever been hospitalized for any surgical operation or serious illness? YES NO
3. Are you taking any medications including non-prescription medicine? YES NO
   If yes, what are you taking?____________
   ____
4. Do you use alcohol or tobacco? YES NO
5. Please list any known allergies.
   ____
   ____
   ____
   ____

WOMEN ONLY

1. Are you pregnant or think you may be pregnant? YES NO
2. Are you nursing? YES NO

Do you have or have you had any of the following? Circle if YES.

High Blood Pressure	Heart Disease	Chest Pains
Heart Attack	Cardiac Pacemaker	Easily Winded
Rheumatic Fever	Heart Murmur	Stroke
Swollen Ankles	Angina	Allergies
Fainting/Seizures	Frequently Tired	Tuberculosis
Asthma	Anemia	Radiation Therapy
Low Blood Pressure	Emphysema	Glaucoma
Epilepsy/Convulsions	Cancer	Significant Weight Loss
Leukemia	Arthritis	Liver Disease
Diabetes	Joint Replacement	Kidney Diseases
Hepatitis/Jaundice	Respiratory Trouble	
AIDS or HIV Infection	Sexually Trans. Dis.	
Thyroid Problem	Stomach Troubles/Ulcers	

DENTAL HEALTH HISTORY

Previous Dentist's Name: ___________________________

#	Question	YES	NO
1.	Do your gums bleed while brushing or flossing?	☐	☐
2.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.	Do you feel pain in any of your teeth?	☐	☐
5.	Do you have any sores or lumps in or near your mouth?	☐	☐
6.	Have you had any head, neck or jaw injuries?	☐	☐
7.	Have you ever experienced jaw clicking, pain, or difficulty in opening or closing?	☐	☐
8.	Do you have frequent headaches?	☐	☐
9.	Do you clench or grind your teeth?	☐	☐
10.	Do you bite your lips or cheeks frequently?	☐	☐
11.	Have you ever had any difficult extractions in the past?	☐	☐
12.	Have you had any orthodontic work?	☐	☐

What is the reason for your visit today?_______________________________________

Have you had dental x-rays taken within the past year? **YES** **NO**

Are you satisfied with the appearance of your teeth? **YES** **NO**

What would you change about your smile? ___________________________________

Do you brush and floss regularly? **YES** **NO** Be honest ☺

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe: ____

I certify that I have read and understand the information stated on this form. To the best of my knowledge, all of the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE____

PATIENT, PARENT, OR GUARDIAN DATE