Medical History

Your current Physical health? Good ☐ Fair ☐ Poor ☐ Are You currently under a physicians care? Yes ☐ No ☐

Explain: ____

Name of primary physician: ______________________ Phone #: ______________

Date of last Physical: __________ Are you currently taking any prescription/over the counter drugs? Yes ☐ No ☐

Please list drugs and reason: ____

Have you ever had any of the following?

Yes ☐	No ☐	**Heart attack/stroke**	Yes ☐	No ☐	**Kidney problems**	Yes ☐	No ☐	**Radiation treatment**
Yes ☐	No ☐	**Heart Murmur/rheumatic fever**	Yes ☐	No ☐	**Psychiatric problems/depression**	Yes ☐	No ☐	**Cancer/chemotherapy**
Yes ☐	No ☐	**Epilepsy/seizures/fainting spells**	Yes ☐	No ☐	**Angina pectoris (chest pain)**	Yes ☐	No ☐	**Severe/frequent headaches**
Yes ☐	No ☐	**Mitral valve prolapse**	Yes ☐	No ☐	**Heart surgery/pacemaker**	Yes ☐	No ☐	**Sinus problems**
Yes ☐	No ☐	**High/low blood pressure**	Yes ☐	No ☐	**Drug/alcohol abuse**	Yes ☐	No ☐	**Tuberculosis (TB)**
Yes ☐	No ☐	**AIDS/HIV**	Yes ☐	No ☐	**Glaucoma**	Yes ☐	No ☐	**Fever blisters**
Yes ☐	No ☐	**Artificial valves/joints**	Yes ☐	No ☐	**Emhpysema**	Yes ☐	No ☐	**Blood transfusion/anemia**
Yes ☐	No ☐	**Diabetes**	Yes ☐	No ☐	**Difficulty breathing**	Yes ☐	No ☐	**Venereal Disease**
Yes ☐	No ☐	**Asthma**	Yes ☐	No ☐	**Arthritis**	Yes ☐	No ☐	**Hospitalized for any reason**
Yes ☐	No ☐	**Thyriod trouble/weight change**	Yes ☐	No ☐	**Hepatitis A or B**			
Yes ☐	No ☐	**Hemophilia/abmormal bleeding**	Yes ☐	No ☐	**Ulcers/colitis**			

Please list any serious medical condition(s) that you have ever had: ______________________________

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Do you use tobacco products? Yes ☐ No ☐ If yes, for how many years? ______________

Are you allergic to any of the following drugs?

Yes ☐	No ☐	**Penicillin**	Yes ☐	No ☐	**Tetracycline**	Yes ☐	No ☐	**No Latex**
Yes ☐	No ☐	**Asprin**	Yes ☐	No ☐	**Dental Anesthetics**	Yes ☐	No ☐	**No Sulfa**
Yes ☐	No ☐	**Erythromycin**	Yes ☐	No ☐	**Codeine**	Yes ☐	No ☐	**Other** ______________

Please list any other foods or drugs to which you are allergic: ______________________________

Dental History

- Name of former dentist: ______________________________ Date of last visit: ________________
- Address of former dentist: ____

  Street City State Zip
- Reason for leaving? ____
- May we send for your records? Yes ☐ No ☐ Are you currently in pain? Yes ☐ No ☐
- Why have you come to the dentist today? ____
- Have you ever had any of the following? ☐ Orthodontics ☐ Oral Surgery ☐ Periodontal Surgery ☐ Root canal Treatment ☐ Implants ☐ Cosmetic Dentistry
- Do your gums ever bleed? Yes ☐ No ☐ Do you like your smile? Yes ☐ No ☐
- If you could change something about your smile, what would it be? _______________________________
- How many times during the day do you brush? ________________ Floss? ________________

Patient signature: ______________________________ Date: ________________