MEDICAL HISTORY

To help us better serve you, please answer all questions completely. All information is confidential.

Name ____________________ Date of Birth ____________

Physician's Name ____________________ Date of Last Physical Exam ____________

In Case of Emergency Notify ____________________ Phone ____________

Do You Have or Have You *Ever* Had:

Heart Murmur / Mitral Valve Prolapse ☐ Yes ☐ No Year ____

Heart Problems (Bypass, Stroke, Angioplasty, other) ☐ Yes ☐ No Year ____

Rheumatic Fever ☐ Yes ☐ No Year ____

Do you have any artificial prosthesis ☐ Yes ☐ No Year ____

(artificial joints or heart valves)

High or Low Blood Pressure ☐ Yes ☐ No Year ____

Asthma ☐ Yes ☐ No Year ____

Shortness of Breath or Emphysema ☐ Yes ☐ No Year ____

Excessive Bleeding or Hemophilia ☐ Yes ☐ No Year ____

Diabetes ☐ Yes ☐ No Year ____

Hepatitis ☐ Yes ☐ No Year ____

H.I.V. / A.I.D.S. ☐ Yes ☐ No Year ____

Circulatory Problems ☐ Yes ☐ No Year ____

Allergies To:

- Anesthetics ☐ Yes ☐ No
- Medicines or Drugs ☐ Yes ☐ No
- Penicillin ☐ Yes ☐ No

Malignancies or Tumors ☐ Yes ☐ No Year ____

Radiation Treatment in head and neck area ☐ Yes ☐ No Year ____

Tuberculosis ☐ Yes ☐ No Year ____

Venereal Disease (STD) ☐ Yes ☐ No Year ____

Are you Pregnant ☐ Yes ☐ No Due ____

Are you presently under the treatment of a physician ☐ Yes ☐ No Year ____

Take "blood-thinner" medications (Aspirin, Coumadin, etc) ☐ Yes ☐ No Year ____

MEDICAL UPDATE

DATE	INITIAL	CHANGE YES / NO

List any other medical condition: ____________________

List current medications taken: ____________________

(please complete other side)

Patient Signature ____________ Date ____________ Dentist Signature ____________ Date ____________

Please answer all questions comletely. All information is confidential.

Are you having any discomfort or pain at this time? Explain _____

Are you sensitive to: Hot _____ Cold _____

Pressure _____ Sweets _____

Are you dissatisfied with the appearance of any of your teeth? _____

Explain _____

Would you like information about whitening your teeth? _____

Did you ever wear braces or retainers? _____ When? _____

Name of Orthodontist : _____

What was the approximate date of last cleaning _____ x-rays _____

How often do you floss your teeth? _____

How often do you brush your teeth? _____

What type of tooth brush do you use? _____

Do you use a water-jet or other such device? _____

Does food wedge between your teeth? _____ Where? _____

Have you ever had gum treatment or gum surgery? _____

Explain _____

Do you ever feel that you have bad breath? _____

Do you have a bad taste in your mouth? _____

Do you ever notice pain or ringing in your ears? _____

Do you have any sinus problems? _____

Are you aware of any lumps or swelling in your mouth or neck? _____

Do you smoke? _____

Is there anything else you think the Dentist should know or is there anything that you would like to discuss with him?

_____