

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Why have you come to see us today? (e.g., pain, checkup, etc.) \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

Reasons for changing dentists: \_\_\_\_\_

Have you had any problems with past dental treatment? \_\_\_\_\_

Have you ever had any prolonged bleeding following extractions or surgery?  Yes  No

Are you nervous about seeing a dentist?  Yes!  No If Yes, please tell us why. \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Do you floss?  Yes  No How often? \_\_\_\_\_

PATIENT'S MEDICAL HISTORY

I consider my health to be (Please check one):  Excellent  Good  Fair  Poor

Do you have or have you had any of the following? Please circle Y for yes or N for no.

1. Y N Heart Disease	25. Y N Liver Disease	
2. Y N Heart Murmur	26. Y N Jaundice	
3. Y N Stroke	27. Y N Hepatitis Type _____	
4. Y N Heart Attack	28. Y N Diabetes	
5. Y N Chest Pain	29. Y N Excessive Urination and/or Thirst	
6. Y N Cardiac Pacemaker	30. Y N Infectious Mononucleosis ("Mono")	
7. Y N Congenital Heart Lesions	31. Y N Herpes	
8. Y N Rheumatic Fever	32. Y N Arthritis, Rheumatism	
9. Y N Abnormal Blood Pressure	33. Y N Sexually Transmitted / Venereal Disease	
10. Y N Anemia	34. Y N Kidney Disease	
11. Y N Prolonged Bleeding Disorder	35. Y N Tumor or Malignancy	
12. Y N Tuberculosis or Lung Disease	36. Y N Cancer / Chemotherapy	
13. Y N Asthma	37. Y N Radiation Therapy	
14. Y N Hay Fever	38. Y N History of Drug Addiction	
15. Y N Sinus Trouble		
16. Y N Epilepsy / Seizures		
17. Y N Ulcers, Stomach Problems		
18. Y N Implants / Artificial Joints. Hip-Knee _____ Other _____		
19. Y N I smoke or use chewing tobacco. If yes, how much per day? How many years?		
20. Y N I have consumed alcohol within the last 24 hours.		
21. Y N I usually take an antibiotic prior to dental treatment.		
22. Y N Have you ever taken Fen-Phen or Redux?		
23. Y N I have had major surgery. Year _____ Type _____ Year _____ Type _____		
24. Y N Do you have any other medical problem or medical history NOT listed on this form? _____		
	39. Y N AIDS	
	40. Y N Immune Suppressed Disorders	
	41. Y N Hearing Loss	
	42. Y N Fainting Spells	
	43. Y N Glaucoma, Eye Disease	
	44. Y N History of Emotional or Nervous Disorders	
	45. Y N Thyroid Problem	
	WOMEN:	
	46. Y N Are you taking birth control medication?	
	47. Y N Are you or could you be pregnant or nursing?	

<p><b>Are you allergic to any of the following?</b> Please circle Y for yes or N for no</p> <ol style="list-style-type: none"> <li>Y N Aspirin</li> <li>Y N Sulfa Drugs / Sulfites / Sulfides</li> <li>Y N Penicillin</li> <li>Y N Codeine</li> <li>Y N Latex, Metals, Plastics</li> <li>Y N Local Anesthetics (Novocaine)</li> <li>Y N Other Medications Which ones? _____</li> </ol>	<p><b>Please list all medications you are currently taking:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are you being treated by a physician now? _____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ FAX _____</p>
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To the best of my knowledge, I have answered every question completely and accurately.

<p>Medical health reviewed by:</p> <p><b>X</b> _____ / /</p> <p style="text-align: center;">Doctor's Signature Date</p>	<p><b>X</b> _____ / /</p> <p style="text-align: center;">Patient's Signature Date</p> <p><b>X</b> _____ / /</p> <p style="text-align: center;">If Patient is a Minor, Parent/Guardian's Signature Date</p>
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