

Medical History

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.

Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Last Visit: _____

Please check any of the following which apply to you and add any relevant comments.

Are you taking any medication? Yes No

If yes, please list: _____

Are you **allergic** to any medication? Yes No

If yes, please list: _____

Do you have a history of any major illness? Yes No

If yes, please explain: _____

Have you had any major operations? Yes No

If yes, please list: _____

Have you ever been involved in a serious accident? Yes No

Please check any of the following that you have had or currently have:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints/Plates (hip,knee,etc) | <input type="checkbox"/> Hepatitis/Liver Problems | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Herpes/Cold Sores/Fever Blisters | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tumor or Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex Allergy/Sensitivity | <input type="checkbox"/> Pregnant/Nursing |

Are there any medical conditions we have not discussed that you feel we should be aware of?

I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature

Date

Dental History

Previous Dentist: _____ Date of Last Visit? _____

Please check any of the following which apply to you and add any relevant comments.

- Are you presently in any dental pain?

Comment: _____

- Have you ever experienced any unfavorable reaction to dentistry?

Comment: _____

- Have you ever lost or chipped any teeth?

Comment: _____

- Have there been any injuries to face, mouth or teeth?

Comment: _____

- Is any part of your mouth sensitive to temperature?

Comment: _____

- Is any part of your mouth sensitive to pressure?

Comment: _____

- Do you have any kind of tongue habit (tongue thrusting)?

Comment: _____

- Are you a mouth breather?

Comment: _____

- Have you ever seen an Orthodontist?

- Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Comment: _____

- Are you aware of your jaws clenching clicking or popping?

Comment: _____

- Are you aware of clenching/grinding your teeth during the day or night?

Comment: _____

- Do you smoke or use tobacco?

Comment: _____

- Do you have "tension" headaches?

Comment: _____

- Have you ever experienced chronic ringing in your ears?

Comment: _____

If there was one thing you could change about your smile, what would it be?
