MEDICAL HISTORY

Patient's Last Name _____First Name _____ Initial _____Date of Birth_____

Physician's Name: _____Phone #:_____ Pharmacy _____Phone #_____
Have you had any metal rods, pins or implants placed? **O** Yes **O** No If yes, when? _____Where? _____
Do you need to take a **premed** (antibiotic) before dental treatment? **O** Yes **O** No If known, what? _____
Please list **ALL** medications, including prescription, over the counter and herbal supplements:

_____
_____

Have you ever taken Fosamax, Boniva, Actonel or other bisphosphonate medications? **O** Yes **O** No When? _____
For Women: Are you using oral contraceptives/hormone replacement? **O** Yes **O** No What? _____
Are you pregnant or think you are pregnant? **O** Yes **O** No Week #:_____ Are you nursing? **O** Yes **O** No

Are you Allergic to any of the following?

O Aspirin **O** Dental Anesthetics **O** Latex **O Penicillin** **O** Sulfa **O** Tetracycline **O** Codeine **O** Erythromycin **O** Metals **O** Other_____

Please circle if you ever had any of the following diseases or medical problems:

Abnormal Bleeding	Congenital Heart Defect	Heart Attack	Liver	Sickle Cell Disease/Traits
Alcohol / Drug Abuse	Diabetes	Heart Murmur	Low Blood Pressure	Sinus Problems
Anemia	Difficulty Breathing	Heart Surgery	Lupus	Stroke
Arthritis	Emphysema	Hemophilia	Mitral Valve Prolapse	Thyroid Problems
Artificial Bones /Joints /Valves	Epilepsy	Hepatitis	Pacemaker	Tuberculosis (TB)
Asthma	Fainting Spells	Herpes / Fever Blisters	Psychiatric Problems	Ulcers
Blood Transfusion	Frequent Headaches	High Blood Pressure	Rheumatic/Scarlet Fever	Venereal Disease
Cancer / Chemo/ Radiation	Glaucoma	HIV+/ AIDS	Seizures	Tobacco Use
Colitis	Hay Fever	Kidney Problems	Shingles	Use Control Substances

Do you have any disease, condition, problem not listed or been hospitalized in the last 5 years? If so, EXPLAIN_____

_____

Dental History

Reason for today's visit _____
_____
Former Dentist: _____
City/State: _____
Date of last dental visit: _____
Date of last dental x-rays: _____
How often do you brush? _____
How often do you floss? _____
Any previous unpleasant dental experiences? __
_____
_____
_____
How do you feel about your teeth in general? ___
_____

Please circle if you have any of the following:

Bad Breath	Jaw pain or tenderness
Bleeding Gums	Lip or cheek biting
Blisters on lips or mouth	Loose teeth or broken fillings
Burning sensation on tongue	Mouth Breathing
Chew on one side of mouth	Mouth pain
Clicking or popping jaw	Orthodontic treatment
Dry Mouth	Pain around ear
Fingernail Biting	Periodontal treatment
Food collection between the teeth	Sensitivity to cold
Foreign objects in mouth	Sensitivity to heat
Grinding teeth	Sensitivity to sweets
Gums swollen or tender	Sensitivity when biting
Gum treatment or surgery	Sores or growths in mouth

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MY MEDICAL STATUS

Patient/Legal Guardian Signature _____ Date_____

Dentist's Signature _____ Date _____

Updated: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____