ACCOUNT #_____ NAME_____ DATE_____

MEDICAL HISTORY

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Physician's Name_____

Physician's Phone_____

Date of last complete physical exam_____

Are you currently under a physician's care? ☐ Y ☐ N

Please explain_____

_____

Do you smoke or use tobacco products? ☐ Y ☐ N

_____

List any prescription or over the counter medications you are currently taking:

Medication Used for

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Latex
Y N Codeine	Y N Tetracycline	Y N Dental Anesthetics
Y N Other	Y N Penicillin	Y N Metals (i.e. jewelry)

Please list other allergies

_____

_____

For Women: Are you pregnant? ☐ Y ☐ N Due date_____

Are you nursing? ☐ Y ☐ N

Are you taking birth control pills? ☐ Y ☐ N

DENTAL HISTORY

How long since last dental exam?_____

Have you ever experienced unfavorable dental treatment?

_____

Is there anything that you would like to change about your smile?

☐ Y ☐ N _____

Do you now have or have you ever experienced discomfort in your jaw joint (TMJ)? ☐ Y ☐ N

Have you ever whitened your teeth? ☐ Y ☐ N

Have you ever had any of the following diseases or medical conditions or a history of taking any medications listed?

Y N Acid Reflux/Heartburn
Y N Arthritis
Y N Artificial Heart Valves
Y N Artificial Joint Replacement
Y N Asthma
Y N Attention Deficit Disorder
Y N Autism
Y N Bacteremia or Endocarditis
Y N Bisphosphonates (Fosamax/Boniva)
Y N Cancer/Chemotherapy/Radiation Treatment
Y N Chronic Snoring or Sleep Apnea
Y N Cold Sores, Fever Blisters, Herpes
Y N Congenital Heart Defect or Heart Murmur
Y N Diabetes
Y N Difficulty Breathing or Emphysema
Y N Drug/Alcohol Abuse
Y N Eating Disorders (Anorexia, Bulimia)
Y N Epilepsy/Seizures
Y N Facial or Collagen Fillers
Y N Fainting Spells
Y N Frequent Headaches or Migraines
Y N Heart Attack
Y N Heart Surgery
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized
Y N Hypothyroid/Hyperthyroid
Y N Kidney Problems
Y N Medical Marijuana Use
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Sinus Problems
Y N Stroke
Y N Tuberculosis
Y N Tumor Benign/Malignant

OFFICE USE ONLY

Premed

Dose

Reason

Alerts

Please indicate any illness or problems not listed above that we should be aware of_____

_____

_____

_____

Signature:_____