

Do you have a personal physician?  Yes  No  
 Physician's Name: \_\_\_\_\_  
 Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Your current physical health is:**  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No  
 Please explain: \_\_\_\_\_  
 Do you smoke or use tobacco in any other form?  Yes  No  
 Have you had any metal rods, pins or implants?  Yes  No  
 Are you taking any prescription / over-the-counter drugs?  Yes  No  
 Please list each one: \_\_\_\_\_  
 Have you ever taken Phen-Fen?  
 Also known as Redux or Pondimin.  Yes  No  
 If so, when? \_\_\_\_\_

**For Women:** Are you taking birth control pills?  Yes  No  
 Are you pregnant?  Yes  No Week #: \_\_\_\_\_  
 Are you nursing?  Yes  No

**Have you ever had any of the following diseases or medical problems**

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia     | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters      |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS                               | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse               | <input type="checkbox"/> Y <input type="checkbox"/> N HIV                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                             | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                             | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion                  | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus                        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy              | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis                            | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect            | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                           | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing               | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema                          | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                           | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells                    | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches                 | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                           | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever                          | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Surgery             | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                       | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease             |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_  
 \_\_\_\_\_

**Are you allergic to any of the following?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin   | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex          | <input type="checkbox"/> Y <input type="checkbox"/> N Other        |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_  
 \_\_\_\_\_

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**MEDICAL HISTORY UPDATE**

Has there been any change in your health status since your last visit?  Y  N  
 If Yes, please explain. \_\_\_\_\_

Has there been any change in your health status since your last visit?  Y  N  
 If Yes, please explain. \_\_\_\_\_

**Why have you come to the dentist today?** \_\_\_\_\_

Are you currently in pain?  Yes  No  
 Do you require antibiotics before dental treatment?  Yes  No

**Your current dental health is:**  Good  Fair  Poor

Have you ever had a serious / difficult problem associated with any previous dental work?  Yes  No  
 Do you floss daily?  Yes  No Brush daily?  Yes  No  
 Type of bristles on your toothbrush?  Hard  Medium  Soft  
 Have you ever had gum treatment?  Yes  No  
 Do your gums ever bleed?  Yes  No Ever Itch?  Yes  No  
 Have you ever had periodontal disease?  Yes  No  
 Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No  
 Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_  
 Do you have any loose teeth?  Yes  No  
 Do you still have wisdom teeth?  Yes  No  
 Would you like fresher breath?  Yes  No Whiter teeth?  Yes  No

**Are you happy with the way your smile looks?**  Yes  No

If not, what would you change? \_\_\_\_\_  
 \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE USE ONLY OFFICE USE ONLY**

I verbally reviewed the medical / dental information with the patient named herein.  
 Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

_____	Patient Signature	_____	Date
_____	Dentist Signature	_____	Date
_____	Patient Signature	_____	Date
_____	Dentist Signature	_____	Date