Patient Name_____ **Address**_____ **Phone;**_____ **Date:** _____

Medical History **Please answer each question. Check Yes or No where applicable.**

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Y N

☐ ☐ **Are you in good health?**

☐ ☐ **Are you now under the care of a physician?**

If so, what is the condition being treated? _____

☐ ☐ **Have you ever had any serious illness, operation or have you been hospitalized?**

If so, what illness or operation? What were you hospitalized for? _____

☐ ☐ **Are you taking any medications?**

If so, what and what dosage: _____

_____

_____

_____

☐ ☐ **Have you ever been pre-medicated with antibiotics for your dental treatment?**

☐ ☐ **Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa drugs ☐ Aspirin ☐ Codeine ☐ Other If other, what drugs?** _____

Do you now have or have you had any of the following: (Please check Yes or No for known conditions.)

Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	**Anemia**	☐	☐	**Hemophilia**	☐	☐	**Drug Addiction**	☐	☐	**Nervous Disorders**	☐	☐	**Sickle Cell Disease**
☐	☐	**Herpes**	☐	☐	**Rheumatism**	☐	☐	**Kidney Disease**	☐	☐	**Tumors or Growths**	☐	☐	**Tuberculosis (T.B.)**
☐	☐	**Stroke**	☐	☐	**Heart Murmur**	☐	☐	**Stomach Ulcers**	☐	☐	**Allergies or Hives**	☐	☐	**Epilepsy or Seizures**
☐	☐	**Diabetes**	☐	☐	**Bruise Easily**	☐	☐	**Angina Pectoris**	☐	☐	**Cortisone Medicine**	☐	☐	**Artificial Joint**
☐	☐	**Glaucoma**	☐	☐	**Head Injuries**	☐	☐	**Mental Disorder**	☐	☐	**Excessive Bleeding**	☐	☐	**Psychiatric Treatment**
☐	☐	**Arthritis**	☐	☐	**Heart Failure**	☐	☐	**Rheumatic Fever**	☐	☐	**Emphysema**	☐	☐	**Congenital Heart Lesion**
☐	☐	**Asthma**	☐	☐	**Liver Disease**	☐	☐	**Thyroid Disease**	☐	☐	**High Blood Pressure**	☐	☐	**Heart Attack**
☐	☐	**Hay Fever**	☐	☐	**Sinus Trouble**	☐	☐	**Cerebral Palsy**	☐	☐	**HIV positive**	☐	☐	**Hepatitis or Jaundice**
☐	☐	**Cold Sores**	☐	☐	**Blood Disease**	☐	☐	**Fainting spells**	☐	☐	**Radiation Treatment**	☐	☐	**Respiratory Disease**
☐	☐	**Chemotherapy (Cancer, Leukemia)**				☐	☐	**Taken Bisphos-**	☐	☐	**Taken Phen Phen**	☐	☐	**Latex Allergy**
☐	☐	**Venereal Disease (Syphilis, Gonorrhea)**						**phonates(Boniva)**	☐	☐	**Acquired Immune Deficiency Syndrome (AIDS)**			
☐	☐	**Mitral Valve Prolapse**							☐	☐	**Other** _____			

Y N

☐ ☐ **Do you wear a cardiac pacemaker, or have you had heart surgery? When?** _____

☐ ☐ **Do you have any disease, condition or problem not listed that you think I should know about?**

If so, what? _____

☐ ☐ **(Women) Are you pregnant? If so, how many months?** _____

☐ ☐ **(Women) Do you take birth control pills?**

☐ ☐ **Have you ever had any unfavorable reaction from a local anesthetic?**

Dental History:

How long has it been since your last dental examination? _____

Complete mouth x-ray examination? _____ **Dental cleaning?** _____

☐ ☐ **Have you had orthodontic treatment? If so, when?** _____

☐ ☐ **Do you have missing teeth? Was it ever suggested to replace them?** _____

☐ ☐ **Do your gums bleed when brushing your teeth?**

☐ ☐ **Have you ever been told that you have periodontal disease (pyorrhea, gum disease)?**

☐ ☐ **Have you ever had professional instructions on home dental care?**

☐ ☐ **Is any part of your mouth sensitive to temperature or pressure? If so, where?** _____

☐ ☐ **Does food catch between your teeth? If yes, where?** _____

☐ ☐ **Have you noticed or been told that you have unpleasant mouth odor? Have you noticed an unpleasant taste?**

☐ ☐ **Are you dissatisfied with the appearance of your teeth?**

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Signed: _____ Date: _____ Relationship to patient: _____