Dental/Medical History Form

Name:_____Date:_____
Sex: Male / Female Height: _____Weight :_____DOB _____/_____/_____
If you are completing this form for another person, what is your relationship to that person: _____
1. What is your primary dental complaint?_____
2. When was your last dental cleaning?_____ Your last complete dental exam?_____
Your last Full mouth X-Ray? _____ Whom was your last dentist? _____
3. Do you have an uncompleted treatment from your last dental visit?_____
4. Are you satisfied with your simile? Yes /No If No, Why? _____
_____
5. Have you ever been told you have, or have symptoms of gum disease (bleeding gums, sore gums, bad taste or odor in the mouth, loose teeth)? Yes/ No
6. Do you suffer from frequent migraine headaches or have problems with your Jaw Joint? Yes No

For the following questions please circle all answers that apply, if none apply please check none.

Do you have, or have you ever had any of the following: Circle all that apply

Heart Murmur	Rheumatic Fever	Vascular Shunt	High Blood Pressure	Coronary Occlusion
Arteriosclerosis	Stroke	Heart Attack	Chest Pain	Artificial Heart Valves
Heart Defect	Pacemaker	Heart Surgery	Congestive Heart Failure	
AIDS/ HIV	Hepatitis	Tuberculosis	Sexually Transmitted Disease	**NONE**

Are you allergic to any of the following: Circle all that apply

Penicillin	Sulfa	Erythromycin	Local Anesthetics	Other Medicine _____
Codeine	Nickel/Other Metals	Latex		**No Allergies**

Do you have, or have you had, any problems with the following: **Circle all that apply**

Sinus Trouble	Asthma	Bronchitis	Emphysema	Other Respiratory Problems
Diabetes	Thyroid Disorder	Liver Problems	Kidney or Adrenal Problems	Jaundice
Digestive Problems	Colitis	Stomach Ulcer	Hiatal Hernia	
Neurological Problems	Fainting	Seizures	Epilepsy	Mental Health Problems
Depression	Abnormal Bleeding	Clotting Problems	Phlebitis	Anemia Transfusions
Cancer	Tumor(s)	Cyst	Biopsy	
Arthritis	Artificial Joints	Muscle or Bone Disease		**NONE**
Are you Pregnant?	Taking Birth Control?	Nursing?		

Do you: Circle all that apply

Smoke	Drink Alcohol	Use Illegal Drugs	Use Chewing Tobacco/Snuff			

Have you ever been : Hospitalized Operated on
Treated for any other conditions not on this form?_____
Are you currently taking any of the following:
Steroids Tranquilizers Aspirin Blood Pressure Medication Thyroid Medicine
List All Medications you are currently taking: _____
I understand that this medical history is a legal document and that I have answered all of the above questions to ht e best of my ability and knowledge and I will not hold my dentist or any other staff members responsible for any errors or omissions I have made in the completion of this form.

Signature of Patient or Legal Guardian X_____