Patient Name: ____ **DOB**: _______/_______/_______

(Please Print)

Medical History – Have you ever had any of the following? Please check those that apply:

______ Anemia
______ Artificial Joints
______ Asthma
______ Blood Disease
______ Cancer
______ Diabetes
______ Dizziness
______ Epilepsy
______ Excessive Bleeding
______ Fainting
______ Glaucoma
______ Growths
______ Head Injuries
______ Heart Problems
______ Heart Murmur
______ Hepatitis
______ High Blood Pressure
______ HIV/Aids

______ Jaundice
______ Kidney Disease
______ Liver Disease
______ Mental Disorder
______ Mitral Valve Prolapse
______ Nervous Disorder
______ Pacemaker
______ Radiation Treatment
______ Rheumatic Fever
______ Rheumatism
______ Seasonal Allergies
______ Sinus Problems
______ Stomach Problems/Ulcers
______ Stroke
______ Tuberculosis
______ Tumors
______ Venereal Disease
______ ____________________

Surgeries: ____________________________
____
____

Drug Allergies:________________________
____
____
____

Medications Currently Taking:
____
____
____

Any Other Medical Info not listed above:
____
____
____

______ Have you ever been told to take Antibiotics before dental treatment? Y / N

Please Circle Yes or NO to the Following Questions:

Are you presently under the care of a Physician? Y / N
If yes, Who: ____________________________________
& Why: ____
Are you allergic to dental anesthetic? Y / N
Are you aware of a recent weight change? Y / N
Are you subject to frequent urination? Y / N
Are you often thirsty? Y / N
Are you often exhausted or fatigued? Y / N
Are you subject to frequent headaches? Y / N
Are you excessively nervous? Y / N
Are you in good health? Y / N
Do you smoke? Y / N
If yes, how much? ______________________________
Does anyone in your family have diabetes? Y / N
Do you have prolonged bleeding after an injury? Y / N

If Female:

Are you presently in menopause? Y / N
Are you taking birth control pills? Y / N
Are you pregnant? Y / N
If Yes, Due Date: ______________________________

Dental History (Please Circle):

How often do you brush your teeth?
Daily – 3x, 2x, 1x Other: ___________
What type of toothbrush do you use?
Electric or Manual (Soft Med Hard)
Do you use Floss? Y / N
How often do you go to the Dentist?
Yearly – Once, Twice, Other: _______
When was your last Cleaning? _______________
Have you had any teeth extracted? Y / N
Reasons for extractions?
Decay, Abscess, Looseness
Do you use Toothpicks? Y / N

Circle if you Have Any of the Following:

Mouth Ulcers — Receding Gums
Bleeding Gums — Halitosis (bad breath)
Sensitive Teeth — Loose Teeth
Grinding Teeth — Past Periodontal Tx
Clenching — Past Orthodontic Tx
Shifting Teeth — Trench mouth, (Pyorrhea)

Who Treated your Perio / Ortho?
Dr. ____________________________________

Is there anything about your smile that you would like to change or improve? ______________________________
____

Signature: ____ **Date:** _______/_______/________