Version 05/13

MEDICAL & DENTAL HISTORY

(Please Print)	Name	Phone #	DOB	Age	Sex
Patient					☐M ☐F
Spouse/Guardian					☐M ☐F
Mailing Address					
Emergency Contact		**Phone #**		**Relationship**	

Reason for today's visit		**Date of last dental care**	
Former Dentist's Name		**Former Dentist Phone #**	
Physician's Name		**Date of last Physical Exam**	

MEDICATIONS *(List any medications you are taking and the correlating diagnosis)*	**ALLERGIES** *(List all the medications or drugs you are allergic to)*

HEALTH HISTORY *(Please check **YES** or **NO** any of the following which you have had or now have)*

AIDS/HIV	☐Yes ☐No	Heart murmur	☐Yes ☐No	Radiation treatment	☐Yes ☐No
Anemia	☐Yes ☐No	Heart surgery	☐Yes ☐No	Rheumatic fever	☐Yes ☐No
Arthritis, General	☐Yes ☐No	Heart trouble	☐Yes ☐No	Scarlet fever	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Hepatitis	☐Yes ☐No	Shortness of breath	☐Yes ☐No
Artificial heart valves	☐Yes ☐No	High blood pressure	☐Yes ☐No	Sinus trouble	☐Yes ☐No
Asthma	☐Yes ☐No	Joint replacement	☐Yes ☐No	Stroke	☐Yes ☐No
Cancer or tumor	☐Yes ☐No	Kidney disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemical dependency	☐Yes ☐No	Liver disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Diabetes	☐Yes ☐No	Mitral valve prolapsed	☐Yes ☐No	Venereal disease	☐Yes ☐No
Epilepsy / Seizures	☐Yes ☐No	Pacemaker	☐Yes ☐No	Taking birth control pill?	☐Yes ☐No
Glaucoma	☐Yes ☐No	Psychiatric treatment	☐Yes ☐No	Other *(please explain)*	☐Yes ☐No

Have you been treated by a physician or hospitalized in the past year? If **Yes**, explain:	☐Yes ☐No
Have you ever had problems with prolonged bleeding from a cut, injury or tooth extraction?	☐Yes ☐No
Have you had any unusual reaction to "Novocaine" or local anesthetic?	☐Yes ☐No
Are you pregnant or possibly pregnant? If **Yes**, when due?	☐Yes ☐No

DENTAL HISTORY (Please check ***YES*** or ***NO*** If you have had problems with any of the following)

Bad breath	☐Yes ☐No	Loose / broken teeth	☐Yes ☐No	Smoking	☐Yes ☐No
Bleeding gums	☐Yes ☐No	Periodontal treatment	☐Yes ☐No	Sores / growths in mouth	☐Yes ☐No
Clicking / popping jaw	☐Yes ☐No	Sensitivity to cold / hot	☐Yes ☐No	Brush - How often?	
Food between teeth	☐Yes ☐No	Sensitivity to sweets	☐Yes ☐No	Floss - How often?	
Grinding teeth	☐Yes ☐No	Sensitivity when biting	☐Yes ☐No	Mouthwash - How often?	

	Patient / Guardian	Witness / Translated By
Name		
Signature		

********** FOR OFFICE USE ONLY **********

Provider Name		**Provider Comments**
Provider's Signature		

ASA	Pre-med	Allergies	Hepatitis	Heart Condition	Anesthetic	Sedation