Medical History

Patient's Name: _____ Age_____ Today's Date: _____
Reason for today's visit/Main Concern: **Checkup** **Cleaning** **Toothache** **Other**: _____
Are there any other conditions which we should be aware of? **YES** **No** **Explain**:_____
Date of last dental visit? _____ Have you ever had Gum (Periodontal) treatment? **YES** **NO**
Did you have a cleaning? **YES** **NO** Was treatment performed and completed on that visit? **YES** **NO**
Have you ever had any prolonged bleeding after an extraction? **YES** **NO** If yes explain:_____
Have you ever had any problems with past dental treatment? **YES** **NO** If yes explain:_____
Do you clench or grind your teeth? **YES** **NO** When (Day/Night)?_____
Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Disorder)? **YES** **NO**
If yes, specify: _____
Do your gums bleed easily? **YES** **NO** Do you feel you have bad breath? **YES** **NO**
Are your teeth sensitive to hot or cold? **YES** **NO** Do you want your teeth whiter? **YES** **NO**
Are you happy with your smile? **YES** **NO** If no specify: _____
Are you under the care of a doctor at this time? **YES** **NO** If yes specify:_____
Dr. Name:_____ Address:_____ Phone#:_____
Are you allergic to Penicillin, Codeine, Local Anesthetic, or anything else? **YES** **NO**
If yes please specify: _____
Are you currently taking any medications including birth control? **YES** **NO** If yes specify: _____
Are you pregnant? **YES** **NO** How many months? _____ Are you nursing? **YES** **NO**

Do you have or have you ever had any of the following conditions:

ARTIFICIAL HEART VALVE	**YES**	**NO**	HEPATITIS	**YES**	**NO**
AIDS/HIV	**YES**	**NO**	HIGH BLOOD PRESSURE	**YES**	**NO**
ANEMIA	**YES**	**NO**	JAUNDICE	**YES**	**NO**
ARTHRITIS	**YES**	**NO**	JOINT REPLACEMENT	**YES**	**NO**
ASTHMA	**YES**	**NO**	KIDNEY DISEASE	**YES**	**NO**
BISPHOSPHONATE THERAPY	**YES**	**NO**	LATEX ALLERGY	**YES**	**NO**
BLEEDING PROBLEMS	**YES**	**NO**	LIVER PROBLEMS	**YES**	**NO**
CANCER	**YES**	**NO**	LOW BLOOD PRESSURE	**YES**	**NO**
CHEMO OR RADIATION THEREAPY	**YES**	**NO**	LUNG DISEASE	**YES**	**NO**
COSMETIC SURGERY	**YES**	**NO**	PACEMAKER	**YES**	**NO**
DIABETES	**YES**	**NO**	PSYCHATRIC CARE	**YES**	**NO**

Dr. _____ Date _____

DIZZY SPELLS	**YES**	**NO**	RHEUMATIC FEVER	**YES**	**NO**
DRUG ADDICTION	**YES**	**NO**	SINUS TROUBLE	**YES**	**NO**
EMPHYSEMA	**YES**	**NO**	SLEEP APNEA	**YES**	**NO**
EPILEPSY	**YES**	**NO**	TOBACCO USER	**YES**	**NO**
FAINTING	**YES**	**NO**	STROKE	**YES**	**NO**
GLAUCOMA	**YES**	**NO**	THYROID PROBLEMS	**YES**	**NO**
HEART ATTACK OR SURGERY	**YES**	**NO**	TMD OR TMJ PROBLEMS	**YES**	**NO**

To the best of my knowledge, I have answered every question completely and accurately.

Signature_____ Date_____

Dr. _____ Date _____