MEDICAL – DENTAL HISTORY

PATIENT'S NAME_____BIRTHDATE_____

INSTRUCTIONS: To receive treatment in our office all questions on this health form must be answered. The questions asked relate directly to the safe and effective treatment you are to receive. To the best of your ability honest answers must be given. If you are unsure of a question, please discuss the matter with the dentist or one of the staff members. If a question does not relate to you, you may with "N/A" (not applicable) in the space provided, but all questions must be answered. To properly evaluate your current health status it may be necessary for the dentist to contact your physician.
All information given on this form and subsequent interview will be held in the strictest confidence and will not be disclosed without your written permission.

MEDICAL EVALUATION:

1. Name & phone number of your physician_____
2. For Females: Are you pregnant?_____ Due Date_____
3. Date of last visit to your physician_____Purpose of visit_____
4. Do you suffer from any disability? _____If yes describe._____
5. Have you had an allergic reaction to any medications? _____If yes, describe._____
6. Are you taking any drugs, medications, or vitamins?_____If yes, please list _____

   _____

   _____

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7. Are you now or have you ever taken: please circle one or all that you are taking
   Grapefruit, Fosamax, Didronel, Boniva, Actonel, Zometa Aredia
8. Any recreational Drug Use? ___ If yes how often? _____
9. Are you in Drug or Alcohol Recovery? _____
10. Do you have AIDS or / are HIV – positive? _____
11. Have you been consulted or been treated by a psychiatrist, psychologist, or counselor? _____
    If yes, please explain: _____

Have you ever had or been treated for: (if **yes** please give date for diagnosis or treatment)

12. Rheumatic Fever, rheumatic heart disease, heart murmur or congenital heart disease or defect? _____
13. Heart attack, angina heart surgery, a pacemaker, irregular beats? _____
14. Abnormal blood pressure, excessive bleeding, or anemia? _____
15. Diabetis? _____ Cancer, tumors, growths?_____
16. X-ray treatments or chemotherapy?_____
17. Kidney or bladder problems or renal dialysis? _____
18. Hepatitis, jaundice, cirrhosis, or other liver condition? _____
19. Breathing problems, asthma, tuberculosis, or emphysema? _____

20. Stroke, convulsions, or fainting spells? _____

21. Stomach or intestinal disease or ulcers? _____

22. Arthritis or rheumatism? _____

23. Joint replacement surgery? _____

24. Serious injury to head or neck? _____

25. Any sexually transmitted disease? _____

26. Have you ever taken Phen – Fen/ Redux? _____

27. Have you ever been hospitalized or received medical care in the last 5 years? _____ _____

    If yes, please explain._____

28. Are you aware of any other health problem that is not listed? _____

    If yes, please explain. _____

DENTAL EVALUATION:

29. Date and Purpose of your last visit to a Dentist: _____

30. Is there anything you would like to change about the appearance of your teeth or your smile?_____

    If yes, please explain. _____

31. Are your teeth sensitive, chipped, stained, or worn? (please circle all that apply)

32. If you could safely and easily whiten your teeth, would you be interested? _____

33. Do you have concerns about your teeth? ____ If yes, please explain _____

34. Do your gums ever bleed? _____ If yes, When? _____

35. Are any of your teeth loose at all? _____

36. Do you have any sores or growths in your mouth or lip area? _____

37. Does food ever pack or catch between your teeth? _____ If yes, which areas? _____

38. Do you grind / clench your teeth or have any pain/popping in your jaw joints or muscles in the jaw? _____

    _____

39. Do you have any teeth hurting right now? _____ If yes which area? _____

40. Have you ever had a bad experience in a dental office? _____ if yes, please explain? _____

    _____

41. Is there anything we can do to help make your experience in our office more pleasant? _____

    _____

Person Completing Form: _____

Signature Date

Please Print Your Name: _____

IF OTHER THAN PATIENT, INDICATE RELATIONSHIP TO PATIENT: _____