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Please answer the following questions completely and thoroughly to allow our office staff to treat you and your dental needs comprehensively.

Name: _____ Date of Birth: _____ Age: _____

MEDICAL HISTORY

1) Are you in good health? __ Yes __ No

2) Do you have a primary care physician? __ Yes __ No Physician's Name:_____

3) Have you ever been hospitalized? __ Yes __ No If yes, for what: _____

4) Do you use tobacco in any form? __ Yes __ No If yes, how much: _____

5) (Women) Are you pregnant? __ Yes __ No If yes, give due date:_____

Do you have, or have you had, any of the following? (Check all that apply)

__AIDS/HIV+	__Cold Sores/Fever Blisters	__Glaucoma	__Leukemia	__Sinus Problems
__Alzheimer's Disease	__Congenital Heart Disease	__Hay Fever	__Liver Disease	__Smoker
__Anaphylaxis	__Convulsion	__Heart Attack/Failure	__Low Blood Pressure	__Stomach Problems
__Anemia	__Cortisone Medicine	__Heart Murmur	__Lung Disease	__Stroke
__Angina	__Diabetes (I or II)	__Heart Pacemaker	__Migraines	__Swelling of Limbs
__Arthritis/Gout	__Drug Addiction	__Heart Trouble/Disease	__Mitral Valve Prolapse	__Thyroid Disease
__Artificial Heart Valve	__Easily Winded	__Hemophilia	__Pain in Joints	__Tonsillitis
__Artificial Joints	__Emphysema	__Hepatitis A	__Parathyroid Disease	__Tuberculosis
__Asthma	__Epilepsy/Seizures	__Hepatitis B or C	__Psychiatric Treatment	__Tumors or Growths
__Blood Disease	__Excessive Bleeding	__Herpes	__Radiation Treatments	__Ulcers
__Blood Transfusion	__Excessive Thirst	__High Blood Pressure	__Recent Weight Loss	__Venereal Disease
__Breathing Problem	__Fainting/Dizziness	__High Cholesterol	__Renal Dialysis	__Yellow Jaundice
__Bruise Easily	__Frequent Cough	__Hives or Rash	__Rheumatic Fever	
__Cancer	__Frequent Diarrhea	__Hypoglycemia	__Rheumatism	
__Chemotherapy	__Frequent Headaches	__Irregular Heartbeat	__Scarlet Fever	
__Chest Pains	__Genital Herpes	__Kidney Disease	__Shingles	

Other: _____

Do you take, or have you taken, Phen-fen or Redux? __Yes __No

Do you take, or have you taken, Fosamax? __Yes __No

ALLERGIES

__Aspirin __Amoxicillin __Penicillin __Codeine __Percocet

__Latex __Metal __Local Anesthetics __None

Other: _____

PLEASE COMPLETE REVERSE SIDE

CURRENT MEDICATIONS

__Antibiotics/Sulfa Drugs	__Blood Pressure Medication	__Digitalis/Other Heart Medications	__Phen-Fen/Redux
__Antihistamines/Allergy Drugs	__Blood Thinners	__Fosamax	__Recreational Drugs
__Aspirin	__Cold Remedies	__Insulin/Other Diabetes Drugs	__Thyroid Medication
__Birth Control Pills	__Cortisone/Steroids	__Nitroglycerin	__Tranquilizers

Other: _____

_____

DENTAL HISTORY

1) When was your last dental visit? _____

2) Have you ever pre-medicated before dental treatment? __Yes __No If yes, please explain: _____

3) What is your immediate dental need? _____

4) Rate your smile from 1-10 (1=dissatisfied, 10=happy): _____

5) What aspect of your smile would you most like to correct? _____

6) Has anything prevented you from addressing this concern in the past? _____

7) Does dental treatment make you nervous? __No __Slightly __Moderately __Extremely

8) Have you ever had your teeth whitened in the past, including over the counter products? __Yes __No

If yes, please explain: _____

Do you have any of the following?

__Bleeding gums	__Loose teeth	__Unpleasant taste/bad breath
__Sensitivity to heat	__Burning tongue/lips	__Sensitivity to cold
__Frequent blisters on lips/mouth	__Sensitivity to sweets	__Swelling or lumps in the mouth
__Sensitivity to pressure	__Bite your cheeks or lips	__Food impaction
__Clicking or popping in the jaw	__Clenching or grinding	__ Difficulty opening or closing jaw
__Shifting teeth	__Orthodontic treatment (braces)	__Change in bite
__Wisdom teeth removed	__Treated for Periodontal Disease/Surgery	

Other:_____

How often do you brush? _____ Your toothbrush is: __Soft __Medium __Hard

Do you use the following?

__Manual Toothbrush	__Dental Floss	__Mouthwash	__Bottled Water
__Electric Toothbrush	__Breath mints/Altoids	__Fluoride Rinse	__Tap Water

Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my health status.

_____ _____

Signature of patient, parent or legal guardian **Date**