Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Within the past year, have there been any changes in your general health? ____**Yes** ____**No**
Your Primary Care Physician's name & phone number:
_____

Please check any of the following to indicate Yes in response to the question:

___Abnormal Bleeding ___Aids ___Alcohol/Drug Abuse ___Anemia ___Alzheimer's ___Arthritis ___Artificial Joints ___Artificial Heart Valves ___Asthma ___Cancer ___Chemotherapy ___Congenital Heart Defect ___Repaired CHD ___Colitis ___Crohn's Disease ___Depression ___Diabetes ___Epilepsy ___Emphysema ___Glaucoma ___Heart Attack ___Heart Disease ___Heart Murmur ___Heart Surgery ___Hepatitis/Type_____ ___Herpes/Fever Blisters	___High Blood Pressure ___HIV ___Kidney Disease ___Liver Disease ___Low Blood Pressure ___ Lupus ___Mitral Valve Prolapse(MVP) ___Pacemaker ___Previous Infective Endocarditis ___Psychiatric Problems ___Radiation Treatment ___Respiratory Problems ___Rheumatic Fever ___Scarlet Fever ___Seizures ___Shingles ___Sinus Problems ___Stomach Problems ___Stroke ___Thyroid Problems ___Tuberculosis ___Tumors ___Ulcers ___Venereal Disease	**Are you Allergic to any of the following:** ___Aspirin ___ Amoxicillin ___Codeine ___ Clindamycin ___Erythromycin ___Ibuprofen ___Latex ___Morphine ___Penicillin ___Other List: _____ _____ **Please list any current medications:** _____ _____ _____ _____ _____ **Women - Are you pregnant?** **___Yes ___No If Yes when is Your due date _____** **Do you smoke or use any Tobacco products?** **___Yes ___No** **Would you like to discuss having whiter teeth?** **___Yes ___No**

What is the reason for your dental visit today? _____
When was your last visit to the dentist (if to a different office)? _____
What was done on your last dental visit (if to a different office)? _____

How frequently do you brush your teeth? ____3 X a Day ____ 2 X a Day ____ Once a Day ____Weekly ____Seldom
What type of toothbrush do you use? ____Soft ____Medium ____Hard ____Electric
How frequently do you floss your teeth?____ 1 X Day ____ 2-4 X Week ____ 1-6 X Month ____ Seldom ____Never

Please check YES or No in response to the following questions:
Do your gums bleed when you brush or floss? ____ **Yes** ____ **No**
Do your teeth experience sensitivity to cold or hot temperatures? ____ **Yes** ____ **No**
Are any of your teeth currently causing you pain? ____ **Yes** ____ **No**
Do you grind your teeth (either consciously or during sleep)? ____ **Yes** ____ **No**
Are any of your teeth loose, or are you concerned about any teeth loosening? ____ **Yes** ____ **No**
Do you currently have any dental implants, dentures, or partials? ____ **Yes** ____ **No**
Have you ever had any complications following dental treatment? ____ **Yes** ____ **No**
Have you ever had treatment for Periodontal Disease? ____ **Yes** ____ **No** ____ **Don't Know**

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.
I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

_____**Date**_____
Signature of Patient, Parent or Guardian