

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Please check to indicate if you have had any of the following:

- | | | |
|---|--|---|
| <input type="radio"/> AIDS | <input type="radio"/> Glaucoma | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Anemia | <input type="radio"/> Headaches | <input type="radio"/> Sinus trouble |
| <input type="radio"/> Arthritis, Rheumatism | <input type="radio"/> Heart murmur | <input type="radio"/> Skin rash |
| <input type="radio"/> Artificial heart valves | <input type="radio"/> Heart problems | <input type="radio"/> Special diet |
| <input type="radio"/> Artificial joints | <input type="radio"/> Hepatitis (Type _____) | <input type="radio"/> Stroke |
| <input type="radio"/> Asthma | <input type="radio"/> Herpes | <input type="radio"/> Swelling of feet or ankles |
| <input type="radio"/> Back problems | <input type="radio"/> High blood pressure | <input type="radio"/> Swollen neck glands |
| <input type="radio"/> Diabetes | <input type="radio"/> HIV positive | <input type="radio"/> Smoking |
| <input type="radio"/> Family history of diabetes | <input type="radio"/> Jaundice | <input type="radio"/> Thyroid problems |
| <input type="radio"/> Excessive bleeding with surgery | <input type="radio"/> Jaw pain | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Blood disease | <input type="radio"/> Joint replacement | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Cancer | <input type="radio"/> Kidney disease | <input type="radio"/> Tumor or growth of head or neck |
| <input type="radio"/> Chemical dependency | <input type="radio"/> Low blood pressure | <input type="radio"/> Ulcer |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Mitral valve prolapse | <input type="radio"/> Venereal disease |
| <input type="radio"/> Circulatory problems | <input type="radio"/> Nervous problems | <input type="radio"/> Unexplained weight loss |
| <input type="radio"/> Congenital heart lesions | <input type="radio"/> Pacemaker | |
| <input type="radio"/> Cortisone treatments | <input type="radio"/> Psychiatric care | |
| <input type="radio"/> Cough, persistent or bloody | <input type="radio"/> Radiation treatment | |
| <input type="radio"/> Epilepsy | <input type="radio"/> Respiratory disease | |
| <input type="radio"/> Fainting or dizziness | <input type="radio"/> Rheumatic fever | |
| | <input type="radio"/> Scarlet fever | |

WOMEN:

Are you pregnant? _____

Taking birth control pills? _____

Are you nursing? _____

MEDICATIONS

Please list all medications you are currently taking: _____

ALLERGIES (please circle)

Aspirin	Iodine	Penicillin
Barbiturates	Latex	Sulfa
Codeine	Local Anesthetic	Other _____

Pharmacy Name _____ Phone _____

IN CASE OF EMERGENCY CONTACT (someone not living with you)

Name _____ Relationship to patient _____

Address and Phone Number of Emergency Contact Person _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

How often do you floss? _____ How often do you brush? _____

Please check if you have any of the following:

- | | | |
|---|--|---|
| <input type="radio"/> Bad breath | <input type="radio"/> Sores or growths in your mouth | <input type="radio"/> Grinding teeth |
| <input type="radio"/> Clicking or popping jaw | <input type="radio"/> Bleeding gums | <input type="radio"/> Clenching teeth |
| <input type="radio"/> Jaw joint pain | <input type="radio"/> Dry mouth | <input type="radio"/> Lip or cheek biting |
| <input type="radio"/> Loose teeth | <input type="radio"/> Food collection between teeth | <input type="radio"/> Orthodontic treatment |
| <input type="radio"/> Broken fillings | <input type="radio"/> Tiredness of mouth | <input type="radio"/> Swollen/bleeding gums |
| <input type="radio"/> Pain around ear | <input type="radio"/> Mouth breathing | <input type="radio"/> Fingernail biting |
| <input type="radio"/> Sensitivity to heat | <input type="radio"/> Sensitivity to biting | <input type="radio"/> Chewing tobacco |
| <input type="radio"/> Sensitivity to cold | <input type="radio"/> Blisters on lips/mouth | <input type="radio"/> Smoking |

On a scale of 1 - 10, how would you rate your smile? _____

Is there anything you would change about your smile? _____

Patient's Signature

Date

