MEDICAL AND DENTAL HISTORY *(to be completed by patient or guardian)*

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions.

Patient's ☐Current ☐Previous Dentist _____ Date of last dental cleaning _____

Patient's ☐Current ☐Previous Physician _____ Date of last physical exam _____

Please list your chief concerns for treatment _____

What or who motivated you to seek treatment and what do you expect? _____

Describe anything that bothers you about the appearance of your teeth, smile, or face: _____

Describe any injuries or blows to your face, jaw, mouth, or teeth: _____

○Brush your teeth (how often?) _____	○Floss your teeth (how often?) _____	○Drink coffee (how much?) _____
○Wake up with sore or stiff joints	○Diagnosed or treated for TMJ Disorder	○Pain, popping, or locking of jaw joint
○Had orthodontic therapy (braces)	○Dizziness, ringing, or pain in ears	○Clench or grind your teeth
○Diagnosed or treated for gum disease	○Had oral surgery or tissue grafts	○Tooth sensitvity (hot, cold, sweet)
○Bad breath or unpleasant taste in mouth	○Fear of dental treatment	○Tongue thrusting habit
○Suck your thumb, finger, or lip	○Gag easily	○Place high priority on keeping natural

			(If yes, please explain below)
Are you under a physician's care now?	○Yes	○No	_____
Have you ever been hospitalized or had a major operation?	○Yes	○No	_____
Have you ever had a serious head or neck injury?	○Yes	○No	_____
Are you taking any medications, pills, or drugs?	○Yes	○No	_____
Do you take, or have you taken Phen-Fen or Redux?	○Yes	○No	_____
Are you on a special diet?	○Yes	○No	_____
Do you use tobacco?	○Yes	○No	_____
Do you use controlled substances?	○Yes	○No	_____

Women: Are you pregnant or trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Are you allergic to any of the following?

○Aspirin ○Penicillin ○Codeine ○Acrylic ○Metal ○Latex ○Local Anesthetics ○Other _____

Please indicate your preferred pharmacy (name and location): _____

Do you have or have you had any of the following? ***(please indicate yes or no)***

AIDS/HIV Positive ○Yes ○No	Cortizone Medicine ○Yes ○No	Hemophilia ○Yes ○No	Renal Dialysis ○Yes ○No
Alzheimer's Disease ○Yes ○No	Diabetes ○Yes ○No	Hepatitis A ○Yes ○No	Rheumatic Fever ○Yes ○No
Anaphylaxis ○Yes ○No	Drug Addiction ○Yes ○No	Hepatitis B or C ○Yes ○No	Rheumatism ○Yes ○No
Anemia ○Yes ○No	Easily Winded ○Yes ○No	Herpes ○Yes ○No	Scarlet Fever ○Yes ○No
Angina ○Yes ○No	Emphysema ○Yes ○No	High Blood Pressure ○Yes ○No	Shingles ○Yes ○No
Arthritis/Gout ○Yes ○No	Epilepsy or Seizures ○Yes ○No	Hives or Rash ○Yes ○No	Sickle Cell Disease ○Yes ○No
Artificial Heart Valve ○Yes ○No	Excessive Bleeding ○Yes ○No	Hypoglycemia ○Yes ○No	Sinus Trouble ○Yes ○No
Artificial Joint ○Yes ○No	Excessive Thirst ○Yes ○No	Irregular Heartbeat ○Yes ○No	Spinal Bifida ○Yes ○No
Asthma ○Yes ○No	Fainting Spells/Dizziness ○Yes ○No	Kidney Problems ○Yes ○No	Intestinal Disease ○Yes ○No
Blood Disease ○Yes ○No	Frequent Cough ○Yes ○No	Leukemia ○Yes ○No	Stroke ○Yes ○No
Blood Transfusion ○Yes ○No	Frequent Diarrhea ○Yes ○No	Liver Disease ○Yes ○No	Swelling of Limbs ○Yes ○No
Breathing Problem ○Yes ○No	Frequent Headaches ○Yes ○No	Low Blood Pressure ○Yes ○No	Thyroid Disease ○Yes ○No
Bruise Easily ○Yes ○No	Genital Herpes ○Yes ○No	Lung Disease ○Yes ○No	Tonsillitis ○Yes ○No
Cancer ○Yes ○No	Glaucoma ○Yes ○No	Mitral Valve ○Yes ○No	Tuberculosis ○Yes ○No
Chemotherapy ○Yes ○No	Hay Fever ○Yes ○No	Prolapse ○Yes ○No	Tumors or ○Yes ○No
Chest Pains ○Yes ○No	Heart Attack/Failure ○Yes ○No	Pain in Jaw Joints ○Yes ○No	Growths ○Yes ○No
Cold Sores/Fever Blisters ○Yes ○No	Heart Murmur ○Yes ○No	Parathyroid Disease ○Yes ○No	Ulcers ○Yes ○No
Congenital Heart Disorder ○Yes ○No	Heart Pace Maker ○Yes ○No	Psychiatric Care ○Yes ○No	Venereal Disease ○Yes ○No
Convulsions ○Yes ○No	Heart Trouble/Disease ○Yes ○No	Radiation Treat- ○Yes ○No	Yellow Jaundice ○Yes ○No

Please list any other medical conditions or serious illnesses not referenced above: _____

_____

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 medical status.

Patient or Guardian's Signature: _____ Date: _____