Medical History

Name_____ ❑ **Male** ❑ **Female** **Birthdate** _____

Physician_____ **Date of last doctor's visit** _____

Allergies to medication or anesthetic: _____ **Allergies to latex**? ❑ **Yes** ❑ **No**

(Women) Are you pregnant? ❑ **Yes** ❑ **No** **Nursing?** ❑ **Yes** ❑ **No**

Please list ALL medications you are taking, including *non-prescription drugs*, *herbal medications* or *supplements*: _____

_____

Do you have a history of the following?

❑ **AIDS or HIV**	❑ **Cough, Persistent**	❑ **Hepatitis**	❑ **Rheumatic Fever**
❑ **Anemia**	❑ **Diabetes**	❑ **High Blood Pressure**	❑ **Scarlet Fever**
❑ **Arthritis, Rheumatism**	❑ **Emphysema**	❑ **Jaw Pain**	❑ **Seizures**
❑ **Artificial Heart Valve**	❑ **Epilepsy**	❑ **Kidney Disease**	❑ **Shortness of Breath**
❑ **Artificial Joints**	❑ **Fainting**	❑ **Liver Disease**	❑ **Skin Rash**
❑ **Asthma**	❑ **Frequent Infections**	❑ **Mitral Valve Prolapse**	❑ **Stroke**
❑ **Back Problems**	❑ **Glaucoma**	❑ **Mental Illness**	❑ **Swelling of Feet/ankles**
❑ **Blood Disease**	❑ **Headaches**	❑ **Nervous Problems**	❑ **Thyroid Problems**
❑ **Cancer**	❑ **Heart Murmur**	❑ **Organ Transplant**	❑ **Tobacco Habit**
❑ **Chemotherapy**	❑ **Heart Problems**	❑ **Pacemaker**	❑ **Tuberculosis**
❑ **Circulatory Problems**	**Describe** _____	❑ **Radiation Treatment**	❑ **Ulcer**
❑ **Convulsions**	❑ **Hemophilia**	❑ **Respiratory Disease**	❑ **Venereal Disease**

Dentist Comments: _____

_____

_____

Dental History

Reason for today's visit _____

Date of last tooth cleaning _____ **Date of last dental x-rays** _____

Do you like the way your teeth look? ❑ **Yes** ❑ **No**

Please check any of the following conditions that apply to you:

❑ **Bleeding gums**	❑ **Grinding teeth**	❑ **Sensitivity to cold**
❑ **Clicking or popping jaw**	❑ **Loose teeth or broken fillings**	❑ **Sensitivity to biting**
❑ **Food collection between teeth**	❑ **Periodontal (gum) treatment**	❑ **Sores/growths in your mouth**

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Patient signature: _____ **Date:**_____

Update Date:_____

Date:_____

Date:_____