Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking could have an important inter-relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under physicians care now? No Yes Explain:

Have you ever been hospitalized or had a major operation? No Yes

Have you ever had a serious head or neck injury? No Yes

Do you take or have you taken Biophosphonates, Fosomax, Aredia, Zometa, Ortonel or Boniva? (Circle any that apply) No Yes

Are you on a special diet?

Do you use controlled substances? No Yes Do you use Tobacco? No Yes

Are you taking any medications, pills or drugs? Please list:

Do you have any allergies? No Yes Please list:

Do you have or have you had any of the following?

******Condition may require medication*

Aids/HIV	Excessive Thirst	Parathyroid Disease
Alzheimers	Fainting Spells/Dizziness	Psychiatric Care
Anaphylaxis	Frequent Cough	Radiation Treatment
Anemia	Frequent Diarrhea	Recent weight loss
Angina	Frequent headaches	Renal Dialysis
Arthritis/Gout	Genital Herpes	Rheumatic Fever
Artificial Heart Valve*	Glaucoma	Rhumatism
Artificial Joint*	Hay Fever	Scarlet Fever
Asthma	Heart Attack/Failure	Shingles
Blood Disease	Heart Disease	Sickle Cell Disease
Breathing Problems	Heart Murmur	Sinus Trouble
Bruise Easily	Hemophillia	Spina Bifida
Cancer	Hepatitis A, B or C	Stomach/IntestineDisease
Chemotherapy	Herpes	Stroke
Chest Pains	High Blood Pressure	Swelling of Limbs
Cold Sores	Hives or Rash	Thyroid Disease
Congenital Heart Disorder	Hypoglycemia	Tonsilitis
Convulsions	Irregular Heartbeat	Tuberculosis
Cortisone Medicine	Kidney Problems	Tumors or Growths
Diabetes	Low Blood Pressure	Ulcers
Drug Addiction	Lung Disease	Venereal Disease
Emphysema	Lung Disease	Yellow Jaundice
Epilepsy	Mitral Valve Prolapse*	
Excessive Bleeding	Pain in Jaw Joints	

Have you ever had any serious illness not listed above? Yes No

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Comments:

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian Date

Dental History

Date of last Dental Exam?

Are you having any dental discomfort at this time?..Yes No

Do you feel nervous about having dental treatment?..Yes No

Are your teeth sensitive to hot or cold?...Yes No

Are you interested in Whitening your smile?..Yes No

Do you have clicking or popping in your jaw or TMJ?..Yes No

Would you like to change anything about your smile?