Medical History

First name_____ Last Name_____ Date of Birth_____

Have you ever had any of the following? Please check those that apply:

- o AIDS
- o Anemia
- o Arthritis
- o Artificial Joints
- o Asthma
- o Blood Disease
- o Cancer
- o Diabetes
- o Dizziness
- o Epilepsy
- o Excessive Bleeding
- o Fainting
- o Glaucoma
- o Growths
- o Hay Fever
- o Head Injuries
- o Heart Disease
- o Heart Murmur
- o Hepatitis_____
- o High Blood Pressure
- o Jaundice
- o Kidney Disease
- o Liver Disease
- o Mental Disorders
- o Nervous Disorders
- o Pacemaker
- o Currently Pregnant Due Date_____
- o Radiation Treatment
- o Respiratory Problems
- o Rheumatic Fever
- o Rheumatism
- o Sinus Problems
- o Stomach Problems
- o Stroke
- o Tuberculosis
- o Tumors
- o Ulcers
- o Venereal Disease
- o Codeine Allergy
- o Penicillin Allergy
- o OTHER:
- o _____
- o _____

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain:_____

• Name of Physician: _____ Phone: _____

• Please list any current medication you are taking:_____

_____

Dental History

Date of last dental Visit_____ Last Cleaning_____ Last X-rays _____

Previous Dentist Name_____ Phone#_____ State_____

How often do you brush your teeth?_____ How often do you Floss?_____

Reason for today's visit?_____ Currently in pain?_____

What do you like about your smile? _____

Would you change about your smile?_____

Have you ever considered Botox treatments and/or dermal fillers for aesthetic improvements?_____

Do you have any of the following? Please check all that apply

- Bleeding Gums
- Broking Fillings
- Chronic Bad Breath
- Decayed teeth
- Food catches between teeth
- Grinding or clenching of teeth
- Injury to teeth or jaw
- Loose teeth
- Orthodontic treatment
- Periodontal treatment
- Painful or locking Jaw
- Sensitivity to sweet, hot, cold, biting
- Sores, growth, swelling in mouth
- Bite your Cheeks
- Have difficulty getting numb

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature _____ Date _____Relationship to Patient_____