MEDICAL HISTORY

Name _____ Date ____ /____ /____

(Please Circle No or Yes)

1. Has there been a recent change in your health? ..... No Yes
   If yes, please explain: .....
2. When was your last physical examination? .....
3. Are you under the care of a physician? ..... No Yes
   If yes, condition: .....
4. Have you been hospitalized or had a serious illness within the last 5 years? ..... No Yes
   If yes, what was the problem? _____
5. Do you have or have you had any of the following? (please circle if yes)

Artificial Limb or Heart Valve	Arthritis or Rheumatism	Psychiatric or Emotional Disease
Organ Transplant	Heart Murmur	Tested For The AIDS Antibodies
Asthma or Hay Fever	Kidney Problems	Rheumatic Fever or Heart Problem
Fainting Spells or Seizures	Venereal Disease, HIP, ARC	Abnormal Bleeding or blood Disorders
Tuberculosis	Pacemaker	High Low Blood Pressure
Radiation Therapy	Diabetes	Controlled Substances or Alcohol
	Hepatitis or Liver Disease	Smoking or Smokeless Tobacco products

   Other _____
6. Do you have any difficulty breathing through your nose? ..... No Yes
7. Are you currently taking any medication? ..... No Yes
   If yes please list: .....
   .....
8. Are you allergic or do you have addictions to any drugs or medications such as Penicillin, Codeine, Cocaine, Aspirin or Alcohol? No Yes
   If yes, describe _____
   _____
9. Are you aware of any lumps in your mouth? ..... No Yes
10. Have you ever had a bad reaction to local or general anesthetic? ..... No Yes
11. Have you ever had excessive bleeding after tooth extraction? ..... No Yes
12. Do you have any disease, condition, or other problems not listed above that you think I should know about? . No Yes
    If yes, describe .....
13. Do you wish to discuss your medical history privately with the doctor? ..... No Yes
14. Physician's Name _____ Phone _____

WOMEN ONLY

1. Are you pregnant? If so, how many months? ..... No Yes
2. Are you taking birth control pills? ..... No Yes
3. Are you breast feeding? ..... No Yes

Patient Signature _____ Date _____

Parent or Guardian Signature (if minor) _____ Date _____

FOR OFFICE USE ONLY

1. What concerns you most about your teeth? _____
2. Are you aware of any dental problems at this time? ..... No Yes
3. Have you had any of the following treatment? Orthodontics (braces), Endodontics (Root Canal), Periodontics (Gum Therapy)? If yes, please specify: ..... No Yes
4. Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth? ..... No Yes
5. Are you aware of grinding or clenching your teeth? ..... No Yes
6. Are you unhappy with the appearance of your smile? ..... No Yes
7. I wish to keep my teeth for my lifetime and want treatment that will help to avoid future problems ..... No Yes
8. My teeth are important, but financial issues could dictate some constraints on treatment. ..... No Yes
9. I want simple care, and it would be all right if I lost my teeth and needed dentures ..... No Yes
10. I don't choose regular care. I want care when I notice a problem ..... No Yes
11. Other _____

_____