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MEDICAL & DENTAL HISTORY

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Age: _____

Physician's Name: _____ Phone: _____ Date of last physical: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Do you have or have you ever had any of the following:

☐ Allergies to Anesthetics
☐ Allergies to Medicine or Drugs
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valves or Joints
☐ Asthma or Hay Fever
☐ Cancer or Tumor
☐ Chemical Dependency
☐ Circulatory Problems
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ General Allergies
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ High Blood Pressure
☐ Hormone Disorder
☐ Kidney Problems
☐ Low Blood Pressure
☐ Mouth Ulcer
☐ Nervous Problems
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Special Diet
☐ Stomach Ulcer
☐ Stroke
☐ Tuberculosis
☐ Venereal Disease
☐ Hepatitis, Jaundice or Liver Disease
☐ AIDS or other Immunosuppressive Disorders

Do you use any of the following? ☐ Birth Control Pills ☐ Amphetamines ☐ Tranquilizers ☐ Tobacco Products

Do you smoke? _____ How many per day? _____ If you have quit, how long ago? _____

Do you have any drug allergies? ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Sulfa ☐ Other: _____

Have you had any adverse reaction to any medicine? _____ If yes, what? _____ Can you handle pain medication? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medications at this time? _____ If yes, which one(s)? _____

_____

Are you now under the care of a physician? _____ For what conditions(s)? _____

Have you ever had any serious illness or operation in the last five years? _____

Date of last dental visit _____ Date teeth were last cleaned _____ How often do you have your teeth cleaned? _____

How often do you brush your teeth? _____ Floss? _____ Do your gums bleed while brushing? _____

Does food catch between your teeth? _____ Do your gums ever feel tender or swollen? _____

Do heat, cold, or sweets cause pain in your mouth? _____ Do you clench your teeth during the day or night? _____

Have you ever been treated for "Trench Mouth" of "Pyorrhea"? _____ Have you had difficult extractions in the past? _____

Have you lost any teeth? _____ Have you ever had Periodontal Treatments or Gum Surgery? _____

Are you subject to prolonged or excessive bleeding? _____ Do you require antibiotics as pre-medication prior to a dental visit? _____

Are you or do you suspect you are pregnant? _____ Anticipated Due Date _____ Are you nursing? _____

YEARLY MEDICAL HISTORY UPDATE (**FOR DOCTOR USE ONLY**)

Have there been any changes in your health or are you taking any new medications?

Date _____ Explanation _____ Signature _____

Date _____ Explanation _____ Signature _____