Name_____ Date_____

1 Medical History

Are you in good health? YES____ NO____
Are you currently under the care of a physician? YES____ NO____
If yes, please explain: _____
Physician's name: _____
Phone: _____
Please list all medications currently being taken:

_____
_____

Do you smoke or use tobacco in any form: YES____ NO____

Have you ever had any of the following? Please circle each one.

AIDS/HIV	Y	N	Hepatitis	Y	N
Allergies	Y	N	High Blood Pressure	Y	N
Anemia	Y	N	Kidney Disease	Y	N
Arthritis	Y	N	Liver Disease	Y	N
Artificial Joints	Y	N	Mental Disorders	Y	N
Artificial Heart Valve(s)	Y	N	Mitral Valve Prolapse	Y	N
Blood Disease	Y	N	Nervous Disorders	Y	N
Cancer	Y	N	Pacemaker	Y	N
Cold Sores/Herpes	Y	N	Pregnancy (Due_____)	Y	N
Diabetes	Y	N	Recent Illness	Y	N
Dizziness	Y	N	Respiratory	Y	N
Eating Disorders	Y	N	Rheumatic Fever	Y	N
Epilepsy	Y	N	Sinus Problems	Y	N
Fainting	Y	N	Tuberculosis	Y	N
Glaucoma	Y	N	Ulcers	Y	N
Heart Murmur	Y	N	Penicillin Allergy	Y	N
Hay Fever	Y	N	Asthma	Y	N
Fen-Phen	Y	N			

ARE YOU ALLERGIC TO OR REACTED ADVERSELY TO:

Local Anesthetic	Y	N	Aspirin	Y	N
Penicillin	Y	N	Codeine	Y	N

Summary of medical history

WOMEN ONLY Are you pregnant? YES____ NO____ Due date_____
Are you nursing? YES____ NO____
Are you using birth control pills? YES____ NO____

_____
_____
_____
_____
_____

Medical history update

_____
_____
_____
_____

3 Consent

I understand that, to the best of my knowledge, the questions on this form have been accurately answered. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or condition.

I authorize the dental staff to perform all necessary dental procedures that I may need with my informed consent. I also give permission to the doctor or his staff to use any photos he may take to be used for lecturing, publishing, or educational purposes.

_____
Signature Date

2 Dental History

Is there anything about your teeth that presently concerns you?

What do you feel is the most important thing we can do for you at this time?

How would you describe the condition of your teeth?
Good ____ Fair ____ Poor ____

How would you describe the condition of your gums?
Good ____ Fair ____ Poor ____

Are you currently having pain or discomfort in your teeth or gums?
YES____ NO____ If yes, please explain: _____

Are you anxious about dental treatment?
Yes_____ No_____

Has the fear of discomfort kept you from regular care?
Yes_____ No_____

Please describe previous experiences with dental offices

_____
_____
_____
_____

Dental Specialists seen

_____
_____
_____

How do you feel about what was done in your mouth?

_____
_____
_____

(DOCTOR USE ONLY)

CONDITIONS
- **Bleeding Gums**
- **Would Like to Improve Smile**
- **Would Like to Have Whiter Teeth**
- **Discoloration/Stain**
- **Concern About Mercury**
- **Concern About Dental Materials**
- **TMD/TMJ Problems**
  - Frequent Headaches
  - TMJ Pain
  - TMJ Noise
  - Limited Opening
  - Ear Congestion
  - Ringing in the Ears
  - Difficulty Swallowing
  - Clenching - Bruxing
  - Facial Pain
  - Neck Pain
  - Postural Problems
  - Tingling Fingers
  - Back Pain
  - Trauma to Jaw
- **Sensitive Teeth**
  - Difficulty Chewing
  - Thermal Sensitivity
  - Loose Teeth
  - Rough Areas
- **Tooth Wear**
  - Chipped Teeth
  - Worn Edges
- **Alignment**
  - Spacing
  - Crowding
  - Crooked
- **Odor/Taste**
  - Food Trap Areas
- **Notes:**

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