**MEDICAL HISTORY**

Name: ________________________________________ Physicians name: _______________________________
Phone: ________________________________________ Phone: ________________________________________

**Y N** Have you been under special care of a medical doctor in the past two years?
**Y N** Are you currently taking any medications? Please list those below; including the amount and frequency .

___________________________ ___________________________ ___________________________ ___________________________
___________________________ ___________________________ ___________________________ ___________________________
___________________________ ___________________________ ___________________________ ___________________________

Please **X** the following that apply.

**Conditions:**

___Abnormal bleeding
___Alcohol or drug dependency
___Allergies
___Angina Pectoris
___Arthritis
___Artificial Heart Valve
___Artificial Joints
___Asthma
___Blood Transfusion
___Chemotherapy
___Cancer
___Congenital Heart Defect
___Diabetes
___Difficulty Breathing
___Emphysema
___Epilepsy
___Fainting Spells
___Fever Blister/Cold Sores
___Glaucoma
___HIV/AIDS
___Heart Attack
___Heart Surgery
___Hemophilia
___Hepatitis
___High Blood Pressure
___Kidney Problems
___Liver Disease
___Mitral Valve Prolapse
___Pace Maker
___Psychiatric Problems
___Radiation Therapy
___Reflux/GERD
___Rheumatic Fever
___Seizures
___Shingles
___Sinus Problems
___Stroke
___Thyroid Problems
___Tuberculosis
___Ulcers
___Venereal Disease

**Allergies:**

___Aspirin
___Codeine
___Dental Anesthetics
___Erythromycin
___Jewelry
___Latex
___Metals
___Penicillin
___Tetracycline
___Other: ____________________

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___**Use of chewing tobacco**
___**Smoke cigarettes**
How much: ____________________

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**If female, please answer the following:**

___Oral contraceptives
___Pregnant # of weeks _____
___Nursing
___Hormone Replacement Therapy

**DENTAL HISTORY**

___Do you have anxiety about dental care?
___Current pain/discomfort in jaw, mouth, etc?
___Have you ever had injury to your face, jaw, or teeth?
___Have you ever had braces?
___Have you had your wisdom teeth extracted?
___Do you wear removable dentures?
___Do you use fluoride toothpaste?
___Do you use fluoride rinses?
___Have you ever taken fluoride supplements?
___Do you drink pop or sports drinks (like Gatorade)?
___Do you drink coffee?
___Do you have well water in your home?

**Notes for office use only:**

______________________________________________________
______________________________________________________
______________________________________________________
______________________________________________________
______________________________________________________
______________________________________________________
______________________________________________________

How long has it been since your last dental check-up? _________ months/years (circle)

Any additional information you would like to share?
__________________________________________________________________________________________
__________________________________________________________________________________________

___I prefer a private setting with the doctor to discuss my Medical History form.

**To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.**

_______________ Date

________________________________________ Signature of patient (parent/guardian)

**For future use only**

Please let us know at any time if you prefer a private setting to discuss changes with the doctor.

**Y N** Are there any changes from the previous answers on this health history form? (If yes, please describe)

Date

Signature of patient (parent/guardian)

**Y N** Are there any changes from the previous answers on this health history form? (If yes, please describe)

Date

Signature of patient (parent/guardian)

**Y N** Are there any changes from the previous answers on this health history form? (If yes, please describe)

Date

Signature of patient (parent/guardian)