MEDICAL HISTORY

Dentist Initials _____

Patient Name _____ Todays Date: _____

Physician _____ Date of Last Exam: _____

Are you under medical treatment now? **Y N**

Are you taking any medication(s), including non- prescription? **Y N**

If yes please list medications:

Do you use tobacco? **Y N**

Do you use alcohol, cocaine or other drugs? **Y N**

Are you wearing contact lenses? **Y N**

Are you allergic to or have you had any reaction to the following:
Local anesthetics **Y N** Penicillin or antibiotics **Y N** Sulfa Drugs **Y N** Barbiturates **Y N**
Sedatives **Y N** Iodine **Y N** Aspirin **Y N** **OTHER:** _____

WOMEN ONLY:

Are you pregnant or think you may be pregnant? **Y N** Are you nursing? **Y N** Are you taking birth control pills? **Y N**

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

High Blood Pressure **Y N**	Asthma **Y N**	Kidney Diseases **Y N**
Heart Attack **Y N**	Low Blood Pressure **Y N**	AIDS or HIV **Y N**
Rheumatic Fever **Y N**	Epilepsy/Convulsions **Y N**	Thyroid Problems **Y N**
Swollen Ankles **Y N**	Leukemia **Y N**	Heart Disease **Y N**
Fainting / Seizures **Y N**	Diabetes **Y N**	Cardiac Pacemaker **Y N**
Heart Murmur **Y N**	Angina **Y N**	Anemia **Y N**
Emphysema **Y N**	Cancer **Y N**	Arthritis **Y N**
Joint replacement/implant **Y N**	Hepatitis **Y N**	Sexually Transmitted Disease **Y N**
Stomach Troubles **Y N**	Chest Pains **Y N**	Radiation Therapy **Y N**

OTHER: _____

DENTAL HISTORY

Do your gums bleed while brushing or flossing? **Y N**

Are your teeth sensitive to hot or cold? **Y N**

Do you feel pain when you brush? **Y N**

Do you feel any pain in your teeth? **Y N**

Do you have any sore or lumps in mouth? **Y N**

Have you had any neck, head or jaw injuries? **Y N**

Have you ever experienced any of the following in your jaw?

a. Clicking
b. Pain (joint/ear/face)
c. Difficulty in chewing
d. Difficulty in opening and closing

Do you have frequent headaches? **Y N**

Do you clinch or grind your teeth? **Y N**

Do you bite your lips or cheek often? **Y N**

Have you ever had any extractions in the past? **Y N**

Have you had orthodontic work? **Y N**

Have you ever had prolonged bleeding after an extraction? **Y N**

Have you ever had instructions on the proper way to brush your teeth? **Y N**

Have you ever had instructions on gum care? **Y N**

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____ _____

Patient, Parent or Guardian **Date**