

Medical History Form

Name: _____ Female Male

Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____

Birth date: ___/___/___ Marital Status: Single Married Widowed

E-Mail address: _____

Name of spouse: _____

Names of Children: _____

How do you enjoy spending your free time? _____

Who can we thank for referring you? _____

Name of personal physician: _____

Physician's Address: _____

Physician's Phone Number: _____ Approximate date of last visit: _____

Current Health condition: Excellent Good Fair Poor

Have you had any serious health problems in the last five years? yes no

If yes, please explain: _____

(For Women) Are you currently pregnant? yes no If yes, how many months? _____

Please list prescription medications: _____

Please list vitamin / herbal supplements: _____

Do you know your blood pressure? yes no (If yes, what is it?) _____

Any history of osteoporosis? yes no

Have you ever taken Bisphosphorates ? yes no
(ie..Fosamax, Boniva, Actonel, Aclasta, Aredia, Zometat)

Please check if you're allergic to any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Codeine / other narcotics |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex sensitivity |
| <input type="checkbox"/> Barbiturates, sedatives, sleeping pills | <input type="checkbox"/> Shellfish, Iodine, or red wine | <input type="checkbox"/> Other: _____ |

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

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/ HIV Positive | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells/ Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of the limbs |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pain in Jaw joints | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack/ Failure | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble/ Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Renal Dialysis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatic Fever | |

Have you ever had any serious illness not listed above? If yes, please explain: _____

Please indicate which specialists you have seen and when:

- Allergist: _____
- Cardiologist: _____
- ENT: _____
- Dermatologist: _____
- Endocrinologist: _____
- Gastroenterologist: _____
- Hematologist: _____
- Nephrologist: _____
- Neurologist: _____
- Oncologist: _____
- Pulmonologist: _____
- Urologist: _____
- Other: _____

Signature _____

Date _____

Dental History Form

On a scale of 1 to 5 (1 low/poor, 5 high/good) please rate:

How do you feel your overall dental health is;.....1 2 3 4 5

Over the last ten years rate how faithfully have you had your teeth cleaned:..... 1 2 3 4 5

What is your level of sensitivity to dental procedures?.....1 2 3 4 5

How do you feel about your smile and the look of your teeth:..... 1 2 3 4 5

What would you want to improve? (Color?, Shape?, Crookedness?) _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Have you ever had gum/ periodontal treatment? Yes No

Do you now or have you ever experienced pain/ Discomfort in your jaw joint(TMJ/TMD)? Yes No

Have you ever been treated for TMJ? Yes No

Have you ever or do you suffer from either tension or migraine headaches? Yes No

Muscle tenderness in jaw/teeth? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums bleed? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of Bristles? Soft Medium Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? Yes No If yes, why? _____

I would like to learn more about:

- Orthodontics
- Whitening
- Cosmetic Dentistry
- Sedation Dentistry
- Implants
- Bridges
- Veneers
- Dentures
- Other _____

Signature _____

Date _____