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, Acturel, Aclasta, Aredia, Zometat)

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

□ Local Anesthetics	□ Sulfa Drugs	□ Codeine / other narcotics
□ Penicillin	□ Aspirin	□ Latex sensitivity
□ Barbiturates, sedatives, sleeping pills	□ Shellfish, Iodine, or red wine	□ Other:_____

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

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