

NAME:

DATE:

Medical History						Dental History					
Do you have any CURRENT HEALTH PROBLEMS?	Yes	No				HOW LONG SINCE you have seen a Dentist? _____					
Are you under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DATE of last COMPLETE dental exam _____					
For what? _____						DATE of last FULL MOUTH X-RAYS _____					
What medications are you taking? _____						YES	NO				
						Have you had any PERIODONTAL (GUM) Treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
						Do your gums BLEED or feel TENDER or IRRITATED	<input type="checkbox"/>	<input type="checkbox"/>			
						Are your teeth SENSITIVE to hot, cold, sweets or pressure (circle)	<input type="checkbox"/>	<input type="checkbox"/>			
FAMILY PHYSICIAN _____						Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Phone No. _____						Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Do you have HEADACHES, EARACHES or NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever been prescribed bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Have you worn BRACES on your teeth before? (ORTHODONTICS)	<input type="checkbox"/>	<input type="checkbox"/>			
(Women) Are you pregnant? How many months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?											
	Yes	No		Yes	No	Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>			
Material Allergies (Latex, wool, metal, chemicals)	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>			
Fen-Phen/Redux	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Does food CATCH between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S./A.R.C./HIV Pos.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any CLICKING in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A(Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	You have any POPPING in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel you have BAD BREATH?	<input type="checkbox"/>	<input type="checkbox"/>			
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Have you EVER had your teeth BLEACHED?	<input type="checkbox"/>	<input type="checkbox"/>			
Mitral Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to have WHITER teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?					
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	(cancer, leukemia)	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	None of the above <input type="checkbox"/>					
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of being allergic to other medications or substances? _____					
Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Specify: _____					
Asthma or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Is there any other Medical or Dental information that you feel we should know about? _____					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____					
			Other	<input type="checkbox"/>	<input type="checkbox"/>						

DATE: _____ SIGNATURE _____

Annual Updates			
Date: _____ Signature _____	Date: _____ Signature _____		
Changes in Health <input type="checkbox"/> NO <input type="checkbox"/> YES (Specify) _____	Changes in Health <input type="checkbox"/> NO <input type="checkbox"/> YES (Specify) _____		
Date: _____ Signature _____	Date: _____ Signature _____		
Changes in Health <input type="checkbox"/> NO <input type="checkbox"/> YES (Specify) _____	Changes in Health <input type="checkbox"/> NO <input type="checkbox"/> YES (Specify) _____		