

Medical History

Physician _____ Phone _____ Last exam _____

Are you under medical care now? Yes ___ No ___ If yes, explain _____

Have you had surgery or been hospitalized within past 5 years? Yes ___ No ___ If yes, explain _____

Are you taking any medications? Yes ___ No ___ Please list _____
(including non-prescription)

Do you use tobacco? Yes ___ No ___ How much/day? _____ How many years? _____

Do you use narcotics/controlled drugs? Yes ___ No ___

Do you wear contact lenses? Yes ___ No ___

Are you pregnant or think you may be pregnant? Yes ___ No ___ Are you nursing? Yes ___ No ___

Are you taking oral contraceptives? Yes ___ No ___

Are you taking aspirin or any blood thinners? Yes ___ No ___

Are you allergic to or have you had any adverse reaction to the following: (circle if yes)

- | | |
|---|---|
| <input type="checkbox"/> Local anesthetic (e.g. Novocain) _____ | <input type="checkbox"/> *Penicillin or other antibiotics _____ |
| <input type="checkbox"/> Barbiturates _____ | <input type="checkbox"/> *Sulfa drugs _____ |
| <input type="checkbox"/> Sedatives _____ | <input type="checkbox"/> *Iodine _____ |
| <input type="checkbox"/> Aspirin _____ | <input type="checkbox"/> *Any metals (nickel, etc) _____ |
| <input type="checkbox"/> Latex rubber _____ | |
| <input type="checkbox"/> Other (please list) _____ | |

Have you ever taken BIPHOSPHONATE drugs (e.g. Actonel, Aredia, Fosamax, Boniva) for osteoporosis or as an adjunctive to chemotherapy, or for any reason? Yes ___ No ___

If yes, for how long? _____ Dosage _____

Do you have or have you had any of the following (circle if yes)

- | | | |
|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> *Leukemia | <input type="checkbox"/> *Respiratory problems |
| <input type="checkbox"/> Heart attack... Date _____ | <input type="checkbox"/> *Cardiac pacemaker | <input type="checkbox"/> *Back or neck pain |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> *Diabetes... Type I or II? | <input type="checkbox"/> *Radiation therapy |
| <input type="checkbox"/> Mitral valve prolapse(w/regurgitation) | <input type="checkbox"/> *Kidney disease | <input type="checkbox"/> *Glaucoma |
| <input type="checkbox"/> Unexplained swollen ankles | <input type="checkbox"/> *AIDS or HIV infection | <input type="checkbox"/> *Hay fever/allergies |
| <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> *Thyroid disease | <input type="checkbox"/> *Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> *Cardiac stent or Artificial heart valve | |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> *Angina | <input type="checkbox"/> *Depression |
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> *Anemia | <input type="checkbox"/> *Stroke |
| <input type="checkbox"/> Frequently exhausted | <input type="checkbox"/> *Emphysema | <input type="checkbox"/> *Heavy bleeding |
| <input type="checkbox"/> Cancer... Type? _____ | <input type="checkbox"/> *Arthritis | <input type="checkbox"/> *Tuberculosis/positive PPD test |
| <input type="checkbox"/> Joint replacement or implant... Date _____ | | <input type="checkbox"/> *Hepatitis/jaundice/liver disease |
| <input type="checkbox"/> Sexually transmitted disease | | <input type="checkbox"/> *Stomach trouble/ulcers |

DENTAL HISTORY Previous dentist _____ Location _____ Last exam _____

Do you have a specific dental concern today? _____

Do you have or have you had any of the following (circle if yes)

- | | |
|---|---|
| <input type="checkbox"/> *Bleeding gums while brushing/flossing | <input type="checkbox"/> *Sensitive teeth (Hot ___ Cold ___ Sweets ___) |
| <input type="checkbox"/> *Pain in any teeth _____ | <input type="checkbox"/> *Sores/lumps in or near your mouth |
| <input type="checkbox"/> *Head/neck/jaw injuries | <input type="checkbox"/> *Difficult dental extractions |
| <input type="checkbox"/> *Frequent headaches | <input type="checkbox"/> *Orthodontic treatment |
| <input type="checkbox"/> *Dentures/partials | <input type="checkbox"/> *Gum surgery or "deep root scaling/planning" |
| <input type="checkbox"/> *Clenching/grinding of teeth | <input type="checkbox"/> *Frequent biting of lips or cheeks |
| <input type="checkbox"/> *Jaw Pain ___ Clicking ___ Difficulty chewing ___ Difficulty opening/closing ___ Locking jaw ___ | |

Check all that apply: Daily flossing ___ Soft brush ___ Medium brush ___ Hard brush ___ Teeth whitening ___

I certify that I have read and understand the above information and have answered to the best of my knowledge. I understand providing incorrect information can be dangerous to my health. I authorize release of any information including diagnosis and dental records rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist/dental group insurance benefits otherwise payable to me. I have read and understand the office financial policy. I agree to allow photographs to be taken for the purpose of documenting dental treatment.

Signature of patient (or parent, if minor)

Date _____

Signature of Examining Doctor

Date _____