4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription / over-the-counter or supplemental drugs? ☐ Yes ☐ No

Please list each one:

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

Y	N		Y	N	
☐	☐	Anemia / Radiation Treatment	☐	☐	Hemophilia / Abnormal Bleeding
☐	☐	Artificial Bones / Joints / Valves	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	High / Low Blood Pressure
☐	☐	Asthma	☐	☐	HIV+ / AIDS
☐	☐	Blood Transfusion	☐	☐	Hospitalized for Any Reason
☐	☐	Cancer / Chemotherapy	☐	☐	Kidney Problems
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse
☐	☐	Diabetes	☐	☐	Psychiatric Problems
☐	☐	Difficulty Breathing	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Drug / Alcohol Abuse	☐	☐	Severe / Frequent Headaches
☐	☐	Emphysema / Glaucoma	☐	☐	Shingles
☐	☐	Epilepsy / Seizures / Fainting Spells	☐	☐	Sickle Cell Disease / Traits
☐	☐	Fever Blisters / Herpes	☐	☐	Sinus Problems
☐	☐	Heart Attack / Stroke	☐	☐	Tuberculosis (TB)
☐	☐	Heart Murmur	☐	☐	Ulcers / Colitis
☐	☐	Heart Surgery / Pacemaker	☐	☐	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Jewelry / Metals	☐	☐	Tetracycline
☐	☐	Dental Anesthetics	☐	☐	Latex	☐	☐	Other

Please list any other drugs / materials that you are allergic to:

5 DENTAL HISTORY

Why have you come to the dentist today?

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

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

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

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

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

!

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: Date:

Doctor's Comments:

MEDICAL HISTORY UPDATE

1. Date: Comments: Signature:

1. Date: Comments: Signature:

1. Date: Comments: Signature: