

MEDICAL HISTORY

Emergency Contact _____

Relationship to Patient _____ Contact's Phone # _____

Are you currently under the care of a physician? _____Y _____N Taking medication? _____Y _____N

If yes, what medication? _____ Taking herbs? _____Y _____N

Family Physician/Group Name _____

Phone # _____

List any major illnesses or surgery (within the last 5 years) _____

Do you smoke? _____Y _____N Do you chew? _____Y _____N If yes, how much? _____

Please Circle any of the following that you have had or have presently:

AIDS/HIV	Drug or alcohol problems	Mitral Valve Prolapse
Allergies	Epilepsy or seizures	Nervous or emotional problems
Anemia	Fainting or dizzy spells	Pacemaker
Arthritis	Heart disease or stroke	Rheumatic fever
Artificial joint (hip, knee)	Heart murmur	Shortness of breath
Asthma	Hemophilia	Thyroid disease
Blood transfusions	Hepatitis or liver problems	Tuberculosis
Cancer-radiation therapy	High/Low blood pressure	Ulcers or stomach problems
Diabetes	Kidney problems	

Please Circle any of the following that you may be allergic to:

Asprin	Penicillin	Dental anesthesia (novocaine)
Codeine	Erythromycin	Latex
Ibuprofen	Tetracycline	Iodine
Other _____		

For women only: _____Yes _____No Are you pregnant at this time?

_____Yes _____No Are you nursing?

_____Yes _____No Are you taking birth control pills?

DENTAL HISTORY Date of last dental visit? _____ Previous Dentist _____

Do you have a specific problem you would like us to check? _____Yes _____No

If yes, please describe: _____

Please circle any of the following that you have had or have presently:

Pain in jaw joint Pain near ears Frequent headaches

Click or pop in jaw Clench or grind teeth Growth of spots in mouth

Bleeding or sore gums Teeth sensitive to hot or cold Problems with extractions

To the best of my knowledge, all of the preceding answers are true and correct. I will not hold this office responsible for errors or omissions that I may have made in the completion of this form. If my health history changes, I will notify this office at my next dental appointment.

Signature of patient or responsible party

Date

Dentist's Signature

Date