NAME Last: First: MI: SEX: M / F _ (Guardian/Parent name if patient is a minor) TODAY'S DATE:_____

MEDICAL HISTORY

Do you have a personal physician?	Y	N	
Physician's Name:		Phone #:	
Reason for last physician visit:			

YOUR CURRENT PHYSICAL HEALTH IS (Circle one):
Good Fair Poor

Do you smoke or use tobacco in any form Y N
Do you have any knee, hip, or joint replacements? Y N
Are you taking any medications? Y N
Please list medications:____

____

____

Have you ever taken Phen-Fen/Redux/Pondimin? Y N
If yes, when?_________
Have you had or been treated for:
Multiple Myeloma Y N
Metastatic Cancer Y N
Pagets Disease Y N
Osteoporosis Y N
Have you had Medication Therapy for Osteoporosis with a Biphosphonate medication (Actonel, Fosamex, Boniva, etc)? Y N
FOR WOMEN: Are you taking birth control pills? Y N
Are you Pregnant? Y N /Week #______
Are you Nursing ? Y N
Ob/Gyn Name:________________ Phone#:________________
Please list any other medical condition(s) that you have or had which are not listed above:____

Have you ever had any of the following diseases or medical problems: (Please answer all that apply)						
Y	N	Alcohol/Drug Abuse		Y	N	Hepatitis
Y	N	Anemia		Y	N	Herpes/Fever Blisters
Y	N	Arthritis		Y	N	High Blood Pressure
Y	N	Artificial Joints/ Valves		Y	N	HIV+/AIDS
Y	N	Asthma		Y	N	Hospitalized for any reason
Y	N	Bleeding Problems		Y	N	Kidney Problems
Y	N	Blood Transfusion		Y	N	Liver Disease
Y	N	Cancer/ Chemotherapy		Y	N	Low Blood Pressure
Y	N	Congenital Heart Defect		Y	N	Mitral Valve Prolapse
Y	N	Diabetes		Y	N	Pacemaker
Y	N	Difficulty Breathing		Y	N	Psychiatric Problem(s)
Y	N	Emphysema		Y	N	Radiation Treatment
Y	N	Epilepsy		Y	N	Rheumatic Fever
Y	N	Fainting/Dizzy Spells		Y	N	Seizures
Y	N	Frequent Headaches/Migraine		Y	N	Shingles
Y	N	Heart Attack		Y	N	Sickle Cell trait/Disiease
Y	N	Heart Murmur		Y	N	Sinus Problems
Y	N	Heart Surgery		Y	N	Stroke
Y	N	Hemophilia		Y	N	Ulcers

Are you allergic to any of the following (Please circle all that apply):		
Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline
Please list any other drugs/materials that you are allergic to:		

DENTAL HISTORY

What is the reason for your visit to our practice today?____

Are you currently in pain? Y N
Do you require antibiotics before dental treatment? Y N

YOUR CURRENT DENTAL HEALTH IS (Circle one): Good Fair Poor

When was your last complete dental evaluation?_____________________
Have you ever had a problem associated with past dental work? Y N
How often do you brush your teeth? _______________________________
How often do you floss your teeth? _______________________________
Would you like fresher breath? Y N
Would you like whiter teeth? Y N
Are you happy with the way your smile looks? Y N
If No, what would you like to improve?____

Have you ever been informed you have or been treated for the following dental conditions: (Please answer all that apply)						
Y	N	Bleeding Gums		Y	N	Mobility of Teeth
Y	N	Bad Taste/Odor		Y	N	Oral Cancer
Y	N	Clicking/Popping Jaw joint		Y	N	Orthodontic Treatment
Y	N	Cold Sores/Ulcers		Y	N	Osseous(Bone) Surgery
Y	N	Deep Cleanings/Scalings		Y	N	TMJ/TMD/ or Jaw pain
Y	N	Gum/Periodontal Disease		Y	N	Toothbrush Abrasion
Y	N	Hot/Cold Sensitivity		Y	N	Wisdom Teeth Extraction

DOCTOR'S COMMENTS/NOTES:	
I verbally reviewed the medical/dental information with the patient (parent) named herein.	
Reviewer's Signature	Date

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.
Patient's (parent/ guardian) Signature:__________________________ Date:______________________

I hearby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation, and/or other medications necessary for the dental treatment to be rendered by the dentist and staff. I agree:__________________ I disagree:__________________

I give consent for the use of photographs for patient education purposes, my name will not be included. I agree:__________________ I disagree:__________________