

MEDICAL HISTORY

Do you have a personal physician? Y N
 Physician's Name: _____
 Address: _____
 Phone#: (____) _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Y N

For Women: Are you taking birth control pills? Y N

Are you pregnant? *Unsure* Y N

Week #: _____ Are you nursing? Y N

Are you allergic to any of the following?

- | | |
|------------------------|----------------------|
| Y N Aspirin | Y N Jewelry / Metals |
| Y N Barbiturates | Y N Latex |
| Y N Codeine | Y N Sedatives |
| Y N Dental Anesthetics | Y N Sulfa Drugs |
| Y N Erythromycin | Y N Tetracycline |
| Y N Penicillin | |

Please list additional drugs/materials that cause allergic reactions:

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin / Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	
Y N Aspirin	Y N Digitalis / Heart Medication	Y N Steroids / Cortisone	

Are you taking any prescriptions, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes No

If yes, please list each one: _____

Do you or have you experienced the following?

- | | | | | |
|-------------------------------|-----------------------------|-------------------------|---------------------------|-----------------------|
| Y N Abnormal Bleeding | Y N Colitis | Y N Headaches | Y N Liver Disease | Y N Shingles |
| Y N Alcohol Abuse | Y N Congenital Heart Defect | Y N Heart Attack | Y N Low Blood Pressure | Y N Sickle Cell |
| Y N Anemia | Y N Diabetes | Y N Heart Murmur | Y N Lupus | Y N Sinus Problems |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Surgery | Y N Mitral Valve Prolapse | Y N Steroid Therapy |
| Y N Artificial Bones / Joints | Y N Drug Abuse | Y N Hemophilia | Y N Pacemaker | Y N Stroke |
| Y N Artificial Valves | Y N Emphysema | Y N Hepatitis A B C | Y N Persistent Cough | Y N Thyroid Problems |
| Y N Asthma | Y N Epilepsy | Y N Herpes | Y N Psychiatric Problems | Y N Tonsillitis |
| Y N Blood Transfusion | Y N Fainting Spells | Y N High Blood Pressure | Y N Radiation Treatment | Y N Tuberculosis (TB) |
| Y N Cancer | Y N Fever Blisters | Y N HIV +/-AIDS | Y N Rheumatic Fever | Y N Ulcers |
| Y N Chemotherapy | Y N Glaucoma | Y N Hospitalized | Y N Scarlet Fever | Y N Venereal Disease |
| Y N Chicken Pox | Y N Hay Fever | Y N Kidney Problems | Y N Seizures | |

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

Why have you come to the dentist today? _____

Are you happy with the way your smile looks? Yes No

If no, Please answer the following questions:

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft My teeth are:

Manual or Electric Toothbrush? Please check one.

Do you use anything in addition to brushing and flossing? Yes No

If yes, what? _____

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

Are your teeth sensitive to heat, cold, or anything else? Yes No

Previous / Present Dentist: _____

Last Visit Date: _____ What did you like most & least about any dentist you have seen?

When I see a picture of myself:

- I wish my teeth were whiter.
- I wish I had a wider or broader smile.
- crowded crooked uneven
- overlapped my teeth have rough edges.
- My gums show too much not enough when I smile.
- My top teeth don't show enough.
- There is too much space between some of my teeth.
- I have discolored areas between my teeth.
- I am not totally pleased with my smile.
- I am interested in options available enhancing my smile.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

SIGNATURE _____

The undersigned hereby authorized Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____. And further authorization and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I give permission for release of any pertinent information about my health that may be necessary for proper diagnosis and treatment. You have my permission to use clinical diagnostic materials such as x-rays, models, photographs, etc. for display or teaching purposes.

Signature _____ Date _____