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Medical History

continued

Your current physical health is:

Good Fair Poor

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

Are you taking any prescription / over-the-counter or herbal supplement drugs? Yes No

Please list each one: _____

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 diseases or medical problems?

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

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

Are you allergic to any of the following?

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

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

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Dental History

Why have you come to the dentist today?

Has your doctor told you that 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 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

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? Hard Medium Soft

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 of 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. I have received a copy of the Notice of Privacy Practices.

Signature _____

Date _____

Payment is due in full at 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 a question 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: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____