MEDICAL HISTORY

Name of Physician: _____ Phone: (___) ___-_____ Date of last exam: __/__/____

Do you have/ had any of the following (please check all that apply):

- □ Heart problems
- □ Heart murmur
- □ Require pre-medication prior to dental treatment
- □ High blood pressure
- □ Pacemaker
- □ Allergy to Penicillin
- □ Latex allergy
- □ Other allergies: _____
- □ Asthma
- □ Tuberculosis
- □ Hepatitis (Type A__B__C__)
- □ Diabetes
- □ Dry Mouth
- □ Tobacco Use
- □ HIV or AIDS
- □ Venereal disease
- □ Artificial joints
- □ Cancer
- □ Epilepsy
- □ Mental disorders
- □ Stroke
- □ Excessive bleeding
- □ Glaucoma
- □ Pregnant? Due date: __/__/___
- □ other medical conditions:

_____

_____

_____

Please list any medications you are currently on:

_____

Have you ever had complications following dental treatment? □ Yes □ No
If yes please explain: _____

Have you been admitted to the hospital in the past two years? □ Yes □ No
If yes please explain: _____

DENTAL HISTORY

Name of previous dentist: _____ Date of last exam: ___/___/____

Do you have any of the following?

- □ Sensitivity to cold or heat
- □ Sensitivity to sweet
- □ Sensitivity to biting
- □ Pain in any of your teeth
- □ Swelling in your face or mouth
- □ Problems with previous dental treatment
- □ Bleeding gums
- □ Loose teeth

Do you like your smile? □ Yes □ No
If no please explain:

_____

Comments:_____

_____

_____

To the best of knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature: _____ Date: ___/___/____
Doctor's Signature:_____ Date: ___/___/____