Medical and Health History

Patient Name: _____ Sex: M F Age: _____
❑child ❑adult ❑senior citizen ❑teenager

Physician: _____ Address: _____
Phone Number: (____)_____-_____ Date of Last Physical: _____

ARE YOU PRESENTLY IN GOOD HEALTH?	❑ YES	❑ NO
Are you currently under medical treatment ?	❑YES	❑NO
If yes, what? _____		
Are you taking any medication regularly?	❑YES	❑ NO
If yes, what? _____		
Have you been hospitalized in the past 2 years?	❑YES	❑NO
If yes, for what? _____		
Have you has any serious illness in the past 5 years?	❑YES	❑NO
If yes, what? _____		

FEMALES PATIENTS ONLY

Are you pregnant?	❑YES	❑NO
If yes, when is your delivery date? _____		
Menstrual Problems?	❑YES	❑ NO
Are you taking birth control?	❑YES	❑ NO

DO YOU HAVE ANY OF THE FOLLOWING:

❑Y ❑N heart trouble	❑Y ❑N hepatitis/jaundice	❑Y ❑N communicable disease
❑Y ❑N heart murmur	❑Y ❑N liver disease	❑Y ❑N fainting problems
❑Y ❑N rheumatic fever	❑Y ❑N bleeding problems	❑Y ❑N dizziness
❑Y ❑N diabetes	❑Y ❑N venereal disease	❑Y ❑N epilepsy
❑Y ❑N low blood pressure	❑Y ❑N thyroid problems	❑Y ❑N hay fever
❑Y ❑N high blood pressure	❑Y ❑N ulcers	❑Y ❑N allergies
❑Y ❑N tuberculosis	❑Y ❑N HIV	❑Y ❑N sinus problems
❑Y ❑N asthma	❑Y ❑N AIDS	❑Y ❑N physical handicap
❑Y ❑N emphysema	❑Y ❑N arthritis	❑Y ❑N nervous disorders

Artificial prosthetic hip or joint replacement? ❑Y ❑N
Have you ever been treated for cancer malignancy? ❑Y ❑N

HAVE YOU EVER HAD A ALLERGIC REACTION OR ALLERGY TO ANY OF THE FOLLOWING?
❑ Penicillin ❑Other antibiotics ❑Local Anesthetic's ❑General Anesthetic's
❑ Aspirin ❑Other Drugs _____

DENTAL HISTORY
Chief Dental Complaints _____ Previous Dentist: _____
Reason for leaving: _____ Address: _____ Phone: _____
Approximately how long since your last dental visit? _____
Are you happy with your dental appearance? _____
Do you take any medications before your dental visit? _____

Last Cleaning:	❑ Less than 6 months	❑ Over 6 months	❑ Over one year
Last Topical Fluoride:	❑ Less than 6 months	❑ Over 6 months	❑ Over one year

Last complete set of X-RAYS or PANORAMIC FILMS:
❑ Less than 6 months ❑ Over 6 months ❑ Over one year

DO YOU HAVE ANY OF THE FOLLOWING?

❑Y ❑N sensitivity or Pain while chewing		❑Y ❑N loose teeth	
❑Y ❑N bleeding gums		❑Y ❑N bad breath	
❑Y ❑N cracked or broken teeth		❑Y ❑N jaw pains	
❑Y ❑N sores in mouth		❑Y ❑N oral habits	
❑Y ❑N problem when flossing		❑Y ❑N tooth grinding	
❑Y ❑N previous gum treatment		❑Y ❑N missing teeth	
❑Y ❑N spaces between teeth		❑Y ❑N sensitivity to hot or cold	
❑Y ❑N crowns or bridges		❑Y ❑N root canal treatment	
❑Y ❑N problems during dental surgery		❑Y ❑N extreme apprehensiveness	

COMMENTS; Please describe any current medical or dental treatment:

_____

Sign: _____ Date: _____