MEDICAL HISTORY

Name:_____ **Have you had any of the following?**

Yes
- □ Pacemaker
- □ Mitral Valve Prolapse
- □ Artificial Heart Valves
- □ Heart Attack/ When_____
- □ Heart Murmur
- □ Rheumatic Fever/When_____
- □ Stroke/ When_____
- □ High Blood Pressure
- □ Anemia
- □ Bleeding Disorder/Hemophiliac
- □ Blood Transfusion, when? _____
- □ Any Immunodeficiency Disorder
- □ A.I.D.S/HIV When? _____
- □ Hepatitis Type _____
- □ Venereal Disease
- □ Liver Problems
- □ Diabetes Type _____
- □ Hypoglycemic

Yes
- □ Glaucoma/Eye Disorder
- □ Cancer/ Malignancies
- □ Radiation/Last Treatment _____
- □ Chemotherapy/Last Treatment_____
- □ Chemical Dependency
- □ Tobacco Habit # Packs per day_____
- □ Shortness of Breath
- □ Cough, Persistent
- □ Cough up Blood
- □ Tuberculosis □ Emphysema
- □ Asthma/Lung Disease
- □ Circulatory Problems
- □ Respiratory Disease
- □ Psychiatric Care/Emotional Problems
- □ Headaches
- □ Neurological Problems
- □ Epilepsy
- □ Sinus Problems
- □ Osteoporosis

Yes
- □ Are you pregnant? Month _____
- □ Thyroid Problems
- □ Ulcer or Colitis
- □ Arthritis/Rheumatism
- □ Jaw Pain
- □ Fainting
- □ Swelling Feet or Ankles
- □ Kidney Problems
- □ Back Problems
- □ Transplant / When_____ Type_____
- □ Joint Replacement in last 2 Yrs? Type_____ When _____

Do you snore? □ Y □ N
Do you feel rested after a full nights rest? □ Y □ N
Have you been diagnosed with Sleep Apnea? □ Y □ N

Are you allergic to?

Yes
- □ Latex
- □ Penicillin/Amoxicillin
- □ Aspirin
- □ Codeine
- □ Sulfa
- □ Keflex
- □ Darvocet
- □ Local Anesthetics
- □ Other _____

List any major surgeries_____
List any medical condition of which you are aware that has not been mentioned:
_____
List any medication you are presently taking:
_____
_____
_____
_____
_____
_____

DENTAL HISTORY

Name of your previous dentist? _____
Reason for leaving previous dentist?_____
My last visit was 6mo. 1yr. 2-3yr. +5yr. ago.
What was done at that time?_____
Last Full Set or Panoramic X-ray _____ **Last bitewing or cavity detection x-rays** _____

How often do you brush? _____

Yes	No		Yes	No	
□	□	Do you use a soft toothbrush?	□	□	Do you clench or grind your teeth?
□	□	Do you use dental floss? How often? _____	□	□	Do your gums bleed?
□	□	Do you have any pain or soreness in teeth or gums?	□	□	Have you had braces?
□	□	Are you teeth sensitive to the following:	□	□	Have you had any teeth removed?
□	□	Sweets? _____ Hot? ____ Cold? _____ Pressure? _____			
□	□	Do you notice popping or clicking in your jaw?			
□	□	Are you satisfied with the appearance of your teeth?			
□	□	Have you ever been told you have gum disease?	□	□	Have you seen a gum specialist?

List any dental condition of which you are aware that has not been mentioned _____
_____
Do you have a dental problem which you believe requires immediate attention? _____
_____
Date: _____ **Patient or Parent's Signature** _____