

4 MEDICAL HISTORY *continued*

Your current physical health is: Good Fair Poor
 Are you currently under the care of a physician? Yes No
 Please Explain: _____
 Are you taking any prescription / over-the-counter drugs? Yes No
 Please list each one: _____
 Do you smoke or use tobacco in any other form? Yes No
For Women: Are you taking birth control pills? Yes No
 Are you pregnant? Yes No Week #: _____
 Are you nursing? Yes No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

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

Please list any serious 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: _____

5 DENTAL HISTORY

Why have you come to the dentist today?

Do 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 now 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 bleed? Yes No
 How many times a week do you floss? _____ a day do you brush? _____
 Type of bristles? Hard Medium Soft
 Have you ever taken Phen-Fen?
 (Also known as Redux or Pondimin) Yes No
 If so, when? _____

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 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.

Signature _____

Date _____

Payment is due in full at the 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 questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

- Date: _____ Comments: _____ Signature: _____
- Date: _____ Comments: _____ Signature: _____
- Date: _____ Comments: _____ Signature: _____