Medical/Dental History

Name _____

Family Physicians Name_____ Phone _____

Are you receiving any health care now? Yes No

List any medications you are taking _____

_____

_____

Do you have or have you had any of the following conditions?

	Yes	No		Yes	No
Heart Condition:					
Abnormal Blood Pressure	☐	☐	HIV Positive	☐	☐
Artificial Valve or Joint	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Osteoporosis	☐	☐
Stroke	☐	☐	Drug or Alcohol Use	☐	☐
Pace Maker	☐	☐	MS	☐	☐
Rheumatic Fever	☐	☐	Depression	☐	☐
High Cholesterol	☐	☐	ADD/ADHD	☐	☐
Prolonged Bleeding	☐	☐	STD/Herpes	☐	☐
Anemia	☐	☐	Sleeping Disorder	☐	☐
Diabetes	☐	☐	Tobacco use	☐	☐
Epilepsy	☐	☐	Allergies	☐	☐
Glaucoma	☐	☐	Penicillin	☐	☐
Hepatitis	☐	☐	Local Anesthetic	☐	☐
Sinus Problems	☐	☐	Codeine	☐	☐
TB (tuberculosis)	☐	☐	Are you taken Bisphosphonates	☐	☐
Kidney Problems	☐	☐	Are you taking Blood Thinners	☐	☐
Stomach or Intestinal problems	☐	☐	Women:		
Arthritis	☐	☐	Are you pregnant?	☐	☐

Is your mouth sensitive to? (Circle) Hot Cold Sweet Chewing

	Yes	No
Have you ever been told you have periodontal or gum disease?	☐	☐
Do your gums bleed when brushing or flossing?	☐	☐
Have you had orthodontic treatment in the past?	☐	☐
Are you interested in having straighter teeth or a smile enhancement?	☐	☐
Do you have any pain or clicking upon opening or closing your jaw?	☐	☐
Are you aware of clenching or grinding of your teeth?	☐	☐

Any dental concerns? Please list _____

_____

_____

Signature _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____