Dental-Medical History

Name of Physician: _____ Phone: _____

☐ Yes ☐ No Are you in good physical health? Date of last physical: _____
☐ Yes ☐ No Are you under a physician's care? Why? _____
☐ Yes ☐ No Are you taking any medications? List: _____
_____
☐ Yes ☐ No Do you have heart problems?
☐ Yes ☐ No Have you had heart valve replacement surgery?
☐ Yes ☐ No Do you have a heart murmur?
☐ Yes ☐ No Have you had joint replacement surgery?
☐ Yes ☐ No Have you ever used Phen-Fen for weight loss?
☐ Yes ☐ No Have you ever had an echocardiogram?
☐ Yes ☐ No Do you bleed or bruise easily?
☐ Yes ☐ No Are you subject to fainting?
☐ Yes ☐ No Women Patients: Are you pregnant? Due Date: _____
☐ Yes ☐ No Do you have any allergies to any medications including penicillin? List: _____
_____
☐ Yes ☐ No Are you allergic to any metals? What? _____
☐ Yes ☐ No Have you ever tested positive for HIV/AIDS?

Do you now have or have you ever had…

☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Blood Disorder
☐ Yes ☐ No Lupus
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Asthma
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Hepatitis Type: _____
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Any other condition we should be aware of? _____

Dental History

☐ Yes ☐ No Do you have sensitivity or allergy to Latex?
☐ Yes ☐ No Have you ever had an adverse or severe reaction to dental treatment?
☐ Yes ☐ No Have you had any problems with oral anesthetics, epinephrine?
☐ Yes ☐ No Do you have any problems that could be aggravated by reclining in a dental chair?
☐ Yes ☐ No Are you pleased with your smile? Concerns? _____
☐ Yes ☐ No Are you interested in whitening your teeth?
☐ Yes ☐ No Do you use tobacco products? What kind? _____ How Often? _____
☐ Yes ☐ No Do you have any muscle soreness when chewing food or gum?
☐ Yes ☐ No Do your gums bleed?

Date of your last: Dental visit? _____ Cleaning? _____ X-rays? _____
Is there anything you would like us to be aware of? _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I understand that I am financially responsible for all charges whether or not paid by the insurance company.

Signature: _____ Date: _____