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: _____