MEDICAL HISTORY

Patient Name: ___________________________________ DOB: ____/____/________

A.) Medical Physician's Name: __________________________

Phone: (____) ____- ________ Date of Last Visit: ____/_______
(Month) (Year)

Are you undergoing any current treatment? Yes No

If yes explain: ____

B.) Your current physical health is: Good Fair Poor

Do you smoke or use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Have you had chemotherapy or radiation treatment? Yes No

If yes, for what? ____

Have you ever been treated with bisphosphonates such as Zometa, Aredia, Actonel, Fosamax or Boniva? Yes No

Have you taken any of the following appetite suppressant drugs Fenfluramine (Pondimin), dexphenfluramine (Redux or phentermine (Fen-phen)? Yes No

C.) Are you taking any prescription and/or over-the-counter medications or herbal supplements?

List: _________________________ _________________________

_________________________ _________________________

_________________________ _________________________

_________________________ _________________________

D.) Are you allergic to any of the following?

Yes	No	Local Anesthetics	Yes	No	Penicillin or other antibiotics
Yes	No	Sulfa Drugs	Yes	No	Aspirin
Yes	No	Iodine	Yes	No	Codeine or other narcotics
Yes	No	Latex	Yes	No	Any metal/plastic (including jewelry)

Other: ____

E.) Have you ever had any of the following disease or medical conditions?

Yes	No	Abnormal Bleeding	Yes	No	Frequent Headaches	Yes	No	Mitral Valve Prolapse
Yes	No	Alcohol/Drug Abuse	Yes	No	Glaucoma	Yes	No	Pacemaker
Yes	No	Anemia	Yes	No	Hay Fever	Yes	No	Psychiatric Problems
Yes	No	Arthritis	Yes	No	Heart Attack	Yes	No	Radiation Treatment
Yes	No	Heart Murmur	Yes	No	Rheumatic/Scarlet Fever	Yes	No	Asthma
Yes	No	Heart Surgery	Yes	No	Seizures	Yes	No	Blood Transfusion
Yes	No	Hemophilia	Yes	No	Shingles	Yes	No	Cancer/Chemotherapy
Yes	No	Herpes/Fever Blisters	Yes	No	Sickle Cell Disease/Traits	Yes	No	Colitis
Yes	No	High Blood Pressure	Yes	No	Sinus Problems	Yes	No	Congenital Heart Defect
Yes	No	HIV/AIDS	Yes	No	Stroke	Yes	No	Diabetes
Yes	No	Hepatitis	Yes	No	Thyroid Problems	Yes	No	Difficulty Breathing
Yes	No	Kidney Problems	Yes	No	Tuberculosis (TB)	Yes	No	Emphysema
Yes	No	Liver Disease	Yes	No	Ulcers	Yes	No	Epilepsy
Yes	No	Low Blood Pressure	Yes	No	Venereal Disease	Yes	No	Fainting Spells
Yes	No	Lupus	Yes	No	Artificial Bones/Joints/Valves	Yes	No	Pregnancy ______Weeks

Please list any serious medical condition(s) that you have ever had that are not on this list.

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Dental History

1. Do you have regular non-emergency dental care? Yes No
2. Have you ever chipped or injured any of your teeth? Yes No
3. Are your teeth sensitive to hot, cold or sweets? Yes No
4. Do you have bleeding gums, bad taste or mouth odor? Yes No
5. Have you ever had periodontal (gum) treatment? Yes No
6. Does food wedge in between your teeth? Yes No
7. Do you get "gum boils"? Yes No
8. Do you get frequent canker sores or cold sores in your mouth or on your lips? Yes No
9. Does your mouth frequently become dry? Yes No
10. Do you have a mouth breathing habit, snoring or difficulty in breathing? Yes No
11. Are you aware of clenching or grinding your teeth while awake or while asleep? Yes No
12. Do you have clicking or locking of your jaws? Yes No
13. Have you ever been treated for TMJ problems? Yes No
14. Have you ever had difficulty in chewing or jaw opening? Yes No
15. Have you ever had orthodontic treatment? Yes No
16. Are you concerned about crooked teeth, protruding teeth or spaces between teeth? Yes No
17. Are you aware of any wisdom teeth problems? Yes No
18. Have you had your wisdom teeth removed? Yes No
19. Do you have any removable dental appliances? Yes No
20. Have you had any serious trouble associated with any previous dental treatment? Yes No
21. Are you happy with your teeth? Yes No
22. When was your last dental visit? _____________ Where? _______________________________________
    Were x-rays taken at that time? Yes No
23. Do you have any dental concerns? Yes No ____

I certify that I have read and understand the above information, to the best of my knowledge; the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X____ ____/____/________

Patient, Parent or Guardian Signature Date