CHART NUMBER

Medical History

Certain illnesses and medications may make it necessary for us to alter your dental treatment. In our endeavor to provide you with the most appropriate health care, it is necessary to collect the following information about your health. Please indicate by checking yes or no for all descriptions that are part of your medical profile. Please be assured that this document will be treated with the utmost confidentiality.

Patient name:

Conditions		
Abdominal Bleeding	☐ Yes	☐ No
Allergy Problems	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back or Neck Pain	☐ Yes	☐ No
Blood Pressure Problems	☐ Yes	☐ No
Blood Disorders	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Bone or Joint Problems	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Cancer / Tumor	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Cosmetic Surgery	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Fever Blisters	☐ Yes	☐ No
Frequent Nosebleeds	☐ Yes	☐ No
Frequent or Severe Headaches	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
HIV-Positive / AIDS	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Heart Valve Problems	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis, Jaundice, Liver Problems	☐ Yes	☐ No
Herpes or Other STD	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No
Kidney or Bladder Problem	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Premedication Required by MD	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Skin Rashes	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Taken Fen-Phen	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
For Women		
Are you using birth control pills?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Medication Allergies		
Aspirin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Dental Anesthetics	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Sulfa	☐ Yes	☐ No
Tetracycline	☐ Yes	☐ No
Other Allergies		
Jewelry	☐ Yes	☐ No
Metals	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Other (specify on next page):	☐ Yes	☐ No
Other Information		
Do you use tobacco products?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
History of alcohol abuse?	☐ Yes	☐ No
Are you on a special diet?	☐ Yes	☐ No
If so, describe:		

CHART NUMBER

Primary care physician:

Name | Phone number

Have you ever been hospitalized? ☐ **YES** ☐ **NO**

If you've been hospitalized, please describe when and purpose:

Please list all medications you are taking:

Please list all other allergies not specified on first page:

Dental History:

Are you apprehensive about going to the dentist?	☐ Yes	☐ No
Are you satisfied with color of your teeth?	☐ Yes	☐ No
Do you have any broken or chipped teeth?	☐ Yes	☐ No
Do you have dental pain?	☐ Yes	☐ No
Are your teeth crowded?	☐ Yes	☐ No
How often do you brush?		
How often do you floss?		

Additional information you would like us to know:

Signed: _____ Date signed: _____

Patient signature

Signed: _____ Date signed: _____

Doctor signature