Medical History

(all responses are kept confidential) Y N

1. Are you under medical treatment now? ☐ ☐

2. Have you ever been hospitalized for any surgical operat./serious illness? ☐ ☐
If yes, please explain: ______________________________

3. Are you taking any medication(s) that include non-prescription? ☐ ☐
If yes, please list:
____
____
____
____

4. Do you use tobacco/alcohol/controlled substances? (if yes, please indicate) ☐ ☐

Y N

5. Are you taking any medication to prevent osteoporosis? ☐ ☐

6. Women only:
Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please advise the doctor if there is any chance of your being pregnant or taking birth control prescriptions.

7. Are you allergic to any of the following? ☐ ☐
(please circle what applies)
- Local Anesthetic (Novocaine, etc.)
- Penicillin, Amoxicillin, Cephalosporins or other Antibiotics
- Barbiturates, Sedatives, etc.
- Aspirin or Ibuprofen
- Codeine or other Pain Killers
- Latex or Rubber Products
- Sulfa
- Other Allergies or Reactions: ____________________

8. Please **check** which of the following applies to you:

High Blood Pressure	☐	Seizures/Epilepsy/Convulsions	☐	Depression/Anxiety/Phobia	☐	Arthritis	☐
Low Blood Pressure	☐	Diabetes	☐	Easily Bruise	☐	Joint replacement/Implant	☐
Fainting	☐	Anemia/Leukemia	☐	Liver Disease	☐	Immune Disease(s)	☐
Heart Attack	☐	Hay Fever/Allergies	☐	Hepatitis/Jaundice	☐	AIDS/HIV infection	☐
Prosthetic Heart Valve	☐	Glaucoma	☐	Tuberculosis	☐	STDs	☐
Cardiac Pacemaker	☐	Organ Transplant	☐	Asthma	☐	Cancer	☐
Rheumatic Fever	☐	Thyroid Problem	☐	Excessive Bleeding	☐	Chemo/Radiation Therapy	☐
Angina/Chest Pain	☐	Stroke	☐	Emphysema/Bronchitis	☐	Schizophrenia/Bipolar	☐
Heart Murmur	☐	Stomach Troubles/Ulcers	☐	Respiratory Problem	☐	Kidney Diseases/Dialysis	☐

Dental History

(all responses are kept confidential) Y N

1. Do your gums bleed easily while brushing/flossing? ☐ ☐
2. Do you feel pain/sensitivity in your teeth? ☐ ☐
3. Do you have any sores or lumps in/near your mouth? ☐ ☐
4. Have you had any head, neck or jaw injuries? ☐ ☐
5. Do you wear dentures/a removable appliance? ☐ ☐

Y N

6. Do you have frequent headaches? ☐ ☐
7. Do you clench/grind your teeth? ☐ ☐
8. Have you experienced pro-longed bleeding post-extraction? ☐ ☐
9. Have you received orthodontic treatment? ☐ ☐
10. Do you have difficulty chewing/swallowing? ☐ ☐

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and dignose my condition. I also give consent for any preventative or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: ____________________ **Date:** __________