

*"Creating healthy, beautiful smiles....for a lifetime."*

**YOUR NAME:** \_\_\_\_\_ Today's Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ When was your last visit to your physician? \_\_\_\_\_

## MEDICAL History

When was your last complete physical? \_\_\_\_\_

Please tell us if you have had any of the following by checking the appropriate box:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Bacterial Endocarditis   | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Any Artificial Replacement | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Blood Disease            | Artificial Knee, Hip, Joint,                        | <input type="checkbox"/> Kidney Problems       |
| <input type="checkbox"/> Irregular Heart Beat     | <input type="checkbox"/> Sickle Cell Anemia       | Pins, Plate   | <input type="checkbox"/> Dialysis              |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Anemia / Blood Problems  | <input type="checkbox"/> Rheumatism / Arthritis     | <input type="checkbox"/> Liver Problems        |
| <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Neurological Problems      | <input type="checkbox"/> Hepatitis             |
| <input type="checkbox"/> Rheumatic Heart Fever    | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Epilepsy / Seizures        | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Rheumatic Heart Disease  | <input type="checkbox"/> Respiratory Disease      | <input type="checkbox"/> Psychiatric Problems       | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Artificial Heart Valves  | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Emotional Problems         | <input type="checkbox"/> Ulcer / Colitis       |
| <input type="checkbox"/> Congenital Heart Lesion  | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Venereal Disease      |
| <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Chemical Dependency        | <input type="checkbox"/> Herpes                |
| <input type="checkbox"/> Heart Attack _____ year  | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> Fever Blisters        |
| <input type="checkbox"/> Angina/ Chest Pain       | <input type="checkbox"/> Eye Disorders / Glaucoma | <input type="checkbox"/> Malignancies               | <input type="checkbox"/> Pregnant _____ months |
| <input type="checkbox"/> Heart Pacemaker          | <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Cancers, Tumors, Growths   | <input type="checkbox"/> Oral Contraceptives   |
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Immunosuppressive        | <input type="checkbox"/> Radiation Treatments       |  |
| <input type="checkbox"/> Congestive Heart Failure | Disorders / ARC                                   |   |  |

Please list any ALLERGIES to Drugs, Medications or Anesthetics: \_\_\_\_\_  
 \_\_\_\_\_

Please list any other MEDICAL CONDITIONS not mentioned above: \_\_\_\_\_  
 \_\_\_\_\_

Please list all DRUGS/MEDICATIONS that you currently take:  
 (Include the dosage and frequency that you are on) \_\_\_\_\_  
 \_\_\_\_\_

## DENTAL History

Please describe your chief oral complaint: \_\_\_\_\_  
 \_\_\_\_\_

- |   |                          |                          |  |                          |                          |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Are your teeth sensitive to :                                   | Yes                      | No                       |  |                          |                          |
| Heat?   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a complete dental examination,                  | Yes                      | No                       |
| Cold?   | <input type="checkbox"/> | <input type="checkbox"/> | including full mouth x-rays, in the past 3 years?            | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweets?   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had your teeth cleaned regularly?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Chewing?  | <input type="checkbox"/> | <input type="checkbox"/> | When was your last cleaning? _____                           |                          |                          |
| Do you have any food traps?                                     | <input type="checkbox"/> | <input type="checkbox"/> | Do you have all or most of your natural teeth?               | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums ever feel tender or swollen?                       | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to keep your natural teeth?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed when brushing?                               | <input type="checkbox"/> | <input type="checkbox"/> | If you've had teeth removed, have they been replaced?        | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any teeth that feel loose?                          | <input type="checkbox"/> | <input type="checkbox"/> | Do you like the appearance of your smile?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been treated for periodontal disease or pyorrhea? | <input type="checkbox"/> | <input type="checkbox"/> | If you could improve your teeth or smile, what would you do? |                          |                          |
| Do you use dental floss?  | <input type="checkbox"/> | <input type="checkbox"/> | _____  |                          |                          |
| Have you had any previous injuries to your face or jaws?        | <input type="checkbox"/> | <input type="checkbox"/> | Do you consider yourself a nervous dental patient?           | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you lose or break fillings?                                  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an unpleasant dental experience?           | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you clench or grind your teeth?                              | <input type="checkbox"/> | <input type="checkbox"/> | When was your last dental appointment? _____                 |                          |                          |
| Do you seem to strike some teeth before others when closing?    | <input type="checkbox"/> | <input type="checkbox"/> | What was done at that visit? _____                           |                          |                          |
| Have you ever had your bite adjusted?                           | <input type="checkbox"/> | <input type="checkbox"/> | _____  |                          |                          |
| Do your jaws ever feel tired or ache?                           | <input type="checkbox"/> | <input type="checkbox"/> | Where was it done? _____                                     |                          |                          |
| Can you chew comfortably on both sides of your mouth?           | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced problems with novocaine?           | <input type="checkbox"/> | <input type="checkbox"/> |

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MEDICAL History Update

YOUR NAME: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ When was your last visit to your physician? \_\_\_\_\_

When was your last complete physical? \_\_\_\_\_

Please tell us if you have had any of the following by checking the appropriate box:

- Bacterial Endocarditis, Heart Murmur, Irregular Heart Beat, High Blood Pressure, Low Blood Pressure, Rheumatic Heart Fever, Rheumatic Heart Disease, Artificial Heart Valves, Congenital Heart Lesion, Mitral Valve Prolapse, Heart Attack, Angina/ Chest Pain, Heart Pacemaker, Heart Surgery, Congestive Heart Failure, Hemophilia, Blood Disease, Sickle Cell Anemia, Anemia / Blood Problems, Excessive Bleeding, Asthma, Respiratory Disease, Shortness of Breath, Hay Fever, Sinus Problems, Tuberculosis, Eye Disorders / Glaucoma, AIDS, Immunosuppressive Disorders / ARC, Any Artificial Replacement, Artificial Knee, Hip, Joint, Pins, Plate, Rheumatism / Arthritis, Neurological Problems, Epilepsy / Seizures, Psychiatric Problems, Emotional Problems, Alcoholism, Chemical Dependency, Drug Addiction, Malignancies, Cancers, Tumors, Growths, Radiation Treatments, Diabetes, Kidney Problems, Dialysis, Liver Problems, Hepatitis, Stroke, Thyroid Problems, Ulcer / Colitis, Venereal Disease, Herpes, Fever Blisters, Pregnant, Oral Contraceptives

Please list any ALLERGIES to Drugs, Medications or Anesthetics: \_\_\_\_\_

Please list any other MEDICAL CONDITIONS not mentioned above: \_\_\_\_\_

Please list all DRUGS/MEDICATIONS that you currently take: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date