Medical / Dental Information

Patients Name: _____ Date of Birth: _____

Medical Doctor: _____

1. Are you presently under the care of a physician? ……. Yes_____ No_____

   If so, why? _____

2. Have you been a patient in the hospital in the last 3 years? ……. Yes_____ No_____

   If so, what were you treated for? _____

3. Are you allergic to ANY medications such as Penicillin, Erythromycin, or Codeine? ….. Yes_____ No_____

   If so, what? _____

   _____

   _____

4. Please list all medications you are taking, including birth control.

   _____

   _____

5. Circle any of the following that you have had or now have.

AIDS-HIV	Cardiac pacemaker	Hepatitis A, B or C	Shortness of breath
Allergies	Congenital heart lesion	High blood pressure	Stroke
Artificial heart valves	Diabetes	Latex allergy	Sinus trouble
Artificial joints	Epilepsy	Organ transplant	Tuberculosis
Asthma	Heart murmur	Periodontal treatment	HPV
Cancer treatment	Heart trouble	Radiation treatment	

6. Do you have any other medical problems or disabilities? …… Yes_____ No_____

   If so, what? _____

7. If female, are you pregnant or nursing? ……... Yes_____ No_____
8. Do you smoke or chew tobacco? …… Yes_____ No_____

   Would you like information on how to quit? ……... Yes_____ No_____

9. Do you have any of the following in/on your mouth, lips, or neck? (please circle)

Swelling in mouth	Swollen purplish gums	Cold sores
Gray-white rash on cheeks or gums	Swollen gland in neck	Canker sores
Gray-white growth on tongue	Bleeding gums	Purplish bruise(s)

   Other problems? _____

10. Have you had unusual bleeding with previous extractions, surgery or injury? …….. Yes_____ No_____
11. Are your teeth sensitive to hot, cold, sweet or pressure? ……. Yes_____ No_____
12. Have you had dental X-rays taken in the last 5 years? ……. Yes_____ No_____

    If so, where? _____

13. What would you like to change about your smile? _____

To the best of my knowledge, all the preceding answers and information provided are true and correct.
If I ever have any changes in my health, I will inform the office at my next appointment.

Signature: _____ Date: _____

Annual Review:
I have reviewed and updated the above and made necessary changes in my medical history.

Signature: _____ Date: _____

Signature: _____ Date: _____