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 **Medical History**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician? **YES NO**

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently being treated for any condition? **YES NO** Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently been hospitalized? **YES NO** Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken medications containing bisphosphonates? (ie. Fosamax, Boniva, Actonel, etc.) **YES NO**

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to the following? **PLEASE CIRCLE ANY THAT PERTAIN TO YOU**

Pollen Latex Dust Food Dye Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Sulfa Drugs Other: Please Explain

List any medication(s) that cause you allergic reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **WOMEN:**

Do you use tobacco? **YES NO** Are you pregnant? **YES NO**

Do you use controlled substances? **YES NO** Are you trying to get pregnant? **YES NO**

 Are you taking oral contraceptives? **YES NO**

 Are you nursing? **YES NO**

**PLEASE CIRCLE ANY THAT PERTAIN TO YOU:**

Anxiety Cerebral Disorders Lung Disease Skin Rash

Abnormal Bleeding Chicken Pox Lupus Stroke

Aids/HIV\* Diabetes Measles -Date of last stroke if any:

Alzheimer’s Disease Seizure Disorder/Epilepsy\* Mitral Valve Prolapse\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anaphylaxis Emphysema Mononucleosis Tonsillitis

Anemia Excessive Gagging Osteoporosis Thyroid Disease

Angina Excessive Bleeding Tumors or Growths Any heart condition\*\*

\*Any Joint replacements Fainting Spells/Dizziness Ulcers - Artificial Valve Replacement

Please Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Glaucoma Pain in jaw joints - Heart Attack

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Herpes Psychiatric Care \*Date of last attack: \_\_\_\_\_\_\_\_

Arthritis/Gout Hearing Impairment Prosthetic Joints\* -Congenital Heart Defects

Attention Deficit Disorder/ADHA Hemophilia\* Radiation Treatments -Heart Transplant

Asthma Hepatitis (A, B or C) \* Rheumatism -Heart Murmur

Autism High Blood Pressure Rheumatoid Arthritis -Heart Pacemaker

Hives High Cholesterol Rheumatic Fever -Heart trouble/Disease

Kidney Problems Hypoglycemia Renal Dialysis -Arrhythmias

Blood Transfusion\* Irregular Heartbeat Sinus Trouble -Infective Endocarditis

Blood Disease Leukemia  Sickle Cell Disease

Cancer Tuberculosis\* Sickle Cell Trait

Chemotherapy Liver Disease Scarlet Fever

Cold Sores/Fever Blisters Low Blood Pressure Sickle Cell Anemia\*

**\*Indicates we will need Medical clearance from doctor’s office or pre-medication is required before appointment**

List all Medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DENTAL HISTORY**

 **PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS**

* Do your gums bleed while brushing or flossing? YES NO
* Are your teeth sensitive to hot or cold liquids/foods? YES NO
* Are you currently experiencing any pain/discomfort YES NO

To any of your teeth?

* Do you have any lumps or sores in or around your mouth? YES NO
* History of Periodontal Disease? YES NO
* Are you happy with your smile? YES NO
* Have you had any head, neck, or jaw surgeries? YES NO
* Do you bite your cheeks/lips frequently? YES NO
* Have you had Orthodontic treatment in the past? YES NO
* Have you ever had any prolonged bleeding following YES NO

Extractions?

* Do you wear dentures/partials? YES NO
* Do you clench or grind your teeth? YES NO
* Do you have frequent headaches? YES NO
* Have you ever experienced any TMJ/jaw issues? YES NO

(I.E.: Clicking, popping, pain, difficulty opening/closing,

Difficulty in chewing)

**Signature of Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**