



Medical/Dental History

Reason for today's visit? _____ Former/Current Dentist: _____

Date of Last Exam: _____ Date of Last X-Rays: _____

How often do you floss? _____ How often do you brush: _____

Please check any of the following conditions that apply to you:

- | | | |
|-------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Sores or Growths in your mouth | <input type="checkbox"/> Food Collection between teeth |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Cigarette, Pipe, or Cigar smoking | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Dip/Chewing Tobacco | <input type="checkbox"/> Sensitivity when biting |

Physician: _____ Date of last visit: _____

- | | | | |
|--------------------------------------------------|----------------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> A Pre-Med | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> HIV | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hydrocodeine Allergy | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergy Sulfa Drugs | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Iodine Allergy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Special Needs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Barbiturates Allergy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Clindamycin Allergy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |

Women: Are you taking birth control pills? ___ Yes ___ No

Are you pregnant? ___ Yes ___ No Due Date: _____ Are you nursing? ___ Yes ___ No

Allergies

If other allergies or medical conditions please indicate:

Medications

List any medications you are currently taking and the reason:

X _____ Date: _____
 Patient or Guardian Relationship