

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Medical Information

Name of Medical Doctor: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

- Yes No Are you under medical treatment now?  
If yes, please explain: \_\_\_\_\_
- Yes No Have you been admitted to a hospital or needed emergency care during the past two years?  
If yes, please explain: \_\_\_\_\_
- Yes No Have you had any operations:  
If yes, please list: \_\_\_\_\_
- Yes No Are you taking any drugs or medications?  
If yes, please list: \_\_\_\_\_
- Yes No Have you had any adverse reactions or allergies to any drugs, latex products, or foods?  
If yes, please list: \_\_\_\_\_

Please check any condition which you now have, are being treated for, or have had in the past:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Alcohol Abuse      | <input type="checkbox"/> Epilepsy/Seizures       | <input type="checkbox"/> Hip Replacement             | <input type="checkbox"/> Shingles           |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Excessive Bleeding      | <input type="checkbox"/> Kidney Dialysis             | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Angina             | <input type="checkbox"/> Fainting/Dizziness      | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Angioplasty        | <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> Kidney Transplant           | <input type="checkbox"/> Tuberculosis (TB)  |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Herpes/Fever Blisters   | <input type="checkbox"/> Knee Replacement            | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Blood Disorder     | <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Low Blood Pressure          | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Head Injuries           | <input type="checkbox"/> Nervous Problems            |   |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Radiation/Chemotherapy      | Due Date: _____                             |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Stent/Bypass      | <input type="checkbox"/> Rheumatic Fever             |   |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Rheumatism                  | <input type="checkbox"/> Tobacco use:       |
| <input type="checkbox"/> Drug Abuse         | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Sinus Problems              | Kind: _____                                 |
| <input type="checkbox"/> Emphysema          | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Stomach/Intestinal Problems | How much per day: _____                     |

Are there any other medical conditions that we should know about? \_\_\_\_\_

## Dental Information

- Yes No Do you have regular dental check-ups? Date of last exam: \_\_\_\_\_
- Yes No Have you had any trouble associated with previous dental treatment?  
If yes, please explain: \_\_\_\_\_
- Yes No Do you clench or grind your teeth?
- Yes No Do your gums bleed when you brush your teeth?
- Yes No Have you noticed any lumps or sores in your mouth?
- Yes No Have you ever had an injury to your face, jaws, or teeth?
- Yes No Are you happy with the appearance of your teeth?
- Yes No Do you want to save your teeth?
- Yes No Has fear ever prevented you from seeking dental treatment?
- Yes No Are you allergic to any metals or dental materials?
- Yes No Are you allergic to "Novocaine"?

Circle the types of dental treatment you have experienced:

Orthodontics (braces)   Dentures   Fillings   Implants   Root canal treatment  
Oral Surgery   Periodontal (gum) treatment   TMJ treatment   Extractions

Are there any other dental conditions that we should know about? \_\_\_\_\_

## Authorization

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_