MEDICAL HISTORY

Have you ever had any of the following diseases or medical problems?

Condition			Condition			Condition		
Heart Attack/Stroke	☐ No	☐ Yes	Sinus Problems	☐ No	☐ Yes	Hemophilia/Abnormal Bleeding	☐ No	☐ Yes
Cancer/Chemotherapy	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Ulcers/Colitis	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Low Blood Pressure	☐ No	☐ Yes	Anemia Treatment	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Fever Blisters	☐ No	☐ Yes	Radiation Treatment	☐ No	☐ Yes
HIV +/ AIDS	☐ No	☐ Yes	Severe/ Frequent Headaches	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Heart Surgery/Pacemaker	☐ No	☐ Yes	Thyroid Condition	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Shingles	☐ No	☐ Yes	Psychiatric Problems	☐ No	☐ Yes	Difficulty Breathing	☐ No	☐ Yes
Congenital Heart Defect	☐ No	☐ Yes	Epilepsy/Seizures/Fainting Spells	☐ No	☐ Yes	Hospitalized for any Reason	☐ No	☐ Yes
Mitral Valve Prolapse	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Kidney Problems/Bladder	☐ No	☐ Yes	Tuberculosis (TB)	☐ No	☐ Yes	Blood Transfusion	☐ No	☐ Yes
Artificial Bones/Joints	☐ No	☐ Yes	Drug/Alcohol Abuse	☐ No	☐ Yes	Emphysema	☐ No	☐ Yes
Artificial Valves	☐ No	☐ Yes	Venereal Disease	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes

Are you taking or scheduled to begin taking either of the following medications:
alendronate (Fosamax) or risedronate (Actonel) for osteoporosis, or Paget's disease, multiple myeloma, or mestastatic cancer? ☐ No ☐ Yes Date treatment began: ____________________

Please list any serious medical condition(s) that you have ever had: ____________________

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Are you allergic to any of the following drugs?

Drug			Drug			Drug		
Penicillin	☐ No	☐ Yes	Tetracycline	☐ No	☐ Yes	Latex	☐ No	☐ Yes
Aspirin	☐ No	☐ Yes	Dental Anesthetics	☐ No	☐ Yes	Sulfa	☐ No	☐ Yes
Erythromycin	☐ No	☐ Yes	Codeine	☐ No	☐ Yes	Other	☐ No	☐ Yes

Please list any other drugs that you are allergic to: ____________________

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What is the reason to come to the dentist today? ____________________

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Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joints (TMJ / TMD)? ☐ No ☐ Yes

Do you suffer from bad breath? ☐ No ☐ Yes

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes

Do your gums ever bleed? ☐ No ☐ Yes

How many times a week do you floss? ____________________

How many times a day do you brush? ____________________

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

I understand that the information that 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 with my informed consent that I may need during diagnosis and treatment.

____________________ Signature ____________________ Date

Payment is due in full at the time of treatment unless prior arrangements have been approved

POS® Reorder # 1126947