MEDICAL HISTORY

Family Doctor _____ Address _____ Phone _____

Date of Birth _____ Receiving any medications? yes ☐ no ☐ What? _____

Do you have any allergies? yes ☐ no ☐ To Penicillin? yes ☐ no ☐ To Codeine? yes ☐ no ☐

To Anesthetic or any other drug? yes ☐ no ☐ Please List _____

Have you had any radiation treatment? yes ☐ no ☐ Are you under the care of a physician? yes ☐ no ☐

Has there been a change in your health in the last 3 years? yes ☐ no ☐ Are you subject to profuse bleeding? yes ☐ no ☐

If female are you pregnant? yes ☐ no ☐ Have you had any operations? yes ☐ no ☐ List _____

Do you have any of the following diseases or problems?

Rheumatic Fever	yes ☐ no ☐	Diabetes	yes ☐ no ☐	Fainting, Seizures	yes ☐ no ☐
High Blood Pressure	yes ☐ no ☐	Asthma	yes ☐ no ☐	Cancer	yes ☐ no ☐
Heart Condition	yes ☐ no ☐	Ulcers/Colitis	yes ☐ no ☐	Anemia	yes ☐ no ☐
Scarlet Fever	yes ☐ no ☐	Kidney	yes ☐ no ☐	Ear or Eye trouble	yes ☐ no ☐
Arthritis	yes ☐ no ☐	Tuberculosis	yes ☐ no ☐	Have you been exposed to the Aids virus?	yes ☐ no ☐
Persistent Cough/Blood	yes ☐ no ☐	Hepatitis	yes ☐ no ☐		

Please explain any of the above conditions: _____

DENTAL HISTORY

What is your present dental problem or concern? _____

When was your last dental visit? _____ Have you had full mouth x-rays? yes ☐ no ☐ Date _____

Have you lost any teeth? yes ☐ no ☐ Why? _____

Missing teeth replaced? yes ☐ no ☐ Do you floss? yes ☐ no ☐ Do your gums bleed? yes ☐ no ☐

Have you ever been treated for gum disease? yes ☐ no ☐ Do you smoke? yes ☐ no ☐

How important are your teeth to you? _____ Do you have any soreness in teeth or gums? yes ☐ no ☐

Are your teeth sensitive to sweets, temperature or pressure? yes ☐ no ☐ Do you have headaches? yes ☐ no ☐

Do you grind or clench your teeth? yes ☐ no ☐ Day ☐ Night ☐

Have you ever had orthodontic treatment? yes ☐ no ☐

Signature _____ Date _____