**Name:** _____ **Sex:** M / F **DOB**_____ **Today's Date:** _____
**Last** **First** **MI**

**If patient is a minor, please provide parent's/guardian's name:**

**MEDICAL HISTORY**

Do you have a personal physician? Y N
Are you currently under a physician's care? Y N
Physician's Name: _____
Phone: _____ Date of last visit: _____
Reason for last visit: _____
Your current physical health is:
Good Fair Poor
Do you smoke or use tobacco in any form? Y N
Are you taking any medications? Y N
Please list: _____
_____
_____

FOR WOMEN ONLY: Are you taking birth control pills? Y N
Are you pregnant? Y N Week#: _____
Are you nursing? Y N

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

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Alcohol/drug abuse | Y | N | Hepatitis |
| Y | N | Anemia | Y | N | Herpes/Fever blisters |
| Y | N | Arthritis | Y | N | High/Low Blood Pressure |
| Y | N | Artificial joints/valves | Y | N | HIV+/AIDS |
| Y | N | Asthma | Y | N | Hospitalized for any reason |
| Y | N | Autism | Y | N | Kidney problems |
| Y | N | Blood transfusion | Y | N | Liver disease |
| Y | N | Cancer/Chemotherapy | Y | N | Mitral Valve Prolaps |
| Y | N | Congenital Heart Defect | Y | N | Pacemaker |
| Y | N | Diabetes | Y | N | Psychiatric problems |
| Y | N | Difficulty breathing | Y | N | Radiation Treatment |
| Y | N | Emphysema | Y | N | Rheumatic Fever |
| Y | N | Epilepsy | Y | N | Seizures |
| Y | N | Fainting/dizzy spells | Y | N | Sickle cell trait/disease |
| Y | N | Frequent migraines | Y | N | Sinus problems |
| Y | N | Heart attack | Y | N | Stroke |
| Y | N | Heart Issues | Y | N | Ulcers |
| Y | N | Heart Surgery | Y | N | Blood Thinners |
| Y | N | Hemophilia or | Y | N | Sleep Apnea |
| Y | N | Bleeding Disorders | Y | N | Depression |
| Y | N | Anxiety | Y | N | Cerebral Palsy |

Please list any other serious medical condition(s) that you have had which are not listed above:
_____
_____

Are you allergic to any of the following? (circle all that apply)

| | | |
|---|---|---|
| Aspirin | Erythromycin | Metals |
| Codeine | Jewelry | Penicillin |
| Dental Anesthetics | Latex | Tetracycline |

Please list any other drugs/materials that you are allergic to and are not listed above:

**DENTAL HISTORY**

What is the primary reason for your visit to our practice today?
_____
_____

Are you currently in pain? Y N
Do you require antibiotics before dental treatment? Y N
Your current DENTAL HEALTH is:
Good Fair Poor
When was the last time you had a complete dental evaluation?
_____
Have you ever had a serious/difficult problem associated with any previous dental work? Y N
Do you floss regularly? Y N
Brush daily? Y N
Have you ever been informed or treated for the following dental conditions:

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Bleeding gums | Y | N | Mobility of teeth |
| Y | N | Bad taste/odor | Y | N | Oral cancer/biopsy |
| Y | N | Cold sores/ulcers | Y | N | Osseous surgery |
| Y | N | Deep cleanings/scaling | Y | N | TMJ/TMD joint pain |
| Y | N | Gum/Periodontal disease | Y | N | Hot/Cold Sensitivity |
| Y | N | Toothbrush abrasion | Y | N | Wisdom teeth extraction |

Would you like fresher breath? Y N
Would you be interested in whiter teeth? Y N
Are you happy with the way your smile looks? Y N
If not, what would you change? _____
_____

I understand that the information I have given today is correct and accurate 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 hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary for dental treatment to be rendered by the dental staff.

_____
Patient's (parent/guardian) Signature Date

Doctor's Comments/Notes: _____
_____
_____
_____
_____

I verbally reviewed the medical/dental information with the patient (parent) named herein.

_____ _____
Reviewer's Signature Date

*1st Update* Any Changes: _____

Patient's (parent) Signature: _____ Date: _____ Reviewed by: _____

*2nd Update* Any Changes: _____

Patient's (parent) Signature: _____ Date: _____Reviewed by: _____

*3rd Update* Any Changes: _____

Patient's (parent) Signature: _____ Date: _____ Reviewed by: _____