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Medical History *continued*

Your Current physical health is: Good Fair Poor
Are you currently under the care of a physician? Yes No

Please Explain: _____
Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one: _____
Do you smoke or use tobacco in any form? Yes No

For Women:
Are you taking birth control pills? Yes No
Are you pregnant? Yes No Week #: _____
Are you nursing? Yes No

**Have you ever had any of the following diseases or medical problems?
(Please circle Y for yes or N for no.)**

- | | | | |
|-----|----------------------------|-----|-----------------------|
| Y N | Abnormal Bleeding | Y N | Heart Surgery |
| Y N | Alcohol abuse | Y N | Hemophilia |
| Y N | Allergies | Y N | Hepatitis A |
| Y N | Anemia | Y N | Hepatitis B |
| Y N | Angina Pectoris | Y N | High Blood Pressure |
| Y N | Arthritis | Y N | HIV+/AIDS |
| Y N | Artificial bones or joints | Y N | Kidney Problems |
| Y N | Artificial Heart Valve | Y N | Liver Disease |
| Y N | Asthma | Y N | Low Blood Pressure |
| Y N | Blood Transfusion | Y N | Mitral Valve Prolapse |
| Y N | Cancer - Chemotherapy | Y N | Pace Maker |
| Y N | Colitis | Y N | Pneumocystitis |
| Y N | Congenital Heart Defect | Y N | Psychiatric Problems |
| Y N | Cosmetic Surgery | Y N | Radiation Therapy |
| Y N | Diabetes | Y N | Rheumatic Fever |
| Y N | Difficulty Breathing | Y N | Seizures |
| Y N | Drug Abuse | Y N | Shingles |
| Y N | Emphysema | Y N | Sickle Cell Disease |
| Y N | Epilepsy | Y N | Sinus Problems |
| Y N | Fainting Spells | Y N | Stroke |
| Y N | Fever Blisters | Y N | Thyroid Problems |
| Y N | Frequent Headaches | Y N | Tuberculosis |
| Y N | Glaucoma | Y N | Ulcers |
| Y N | Hay Fever | Y N | Venereal Disease |
| Y N | Heart Attack | Y N | Yellow Jaundice |
| Y N | Heart Murmur | | |

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

Do you have any allergies?

- | | | | |
|-----|--------------------|-----|---------------------------|
| Y N | Aspirin | Y N | Latex |
| Y N | Codeine | Y N | Metals |
| Y N | Dental Anesthetics | Y N | Penicillin |
| Y N | Erythromycin | Y N | Tetracycline |
| Y N | Jewelry | Y N | Other (please list below) |



are committed to excellence in helping you to achieve oral health. Our goal is to recommend and provide the highest quality of treatment that modern dentistry has to offer to meet your needs, and to do so in a state of the art facility. We are committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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Dental History

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

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

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

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Would you like whiter teeth? Yes No

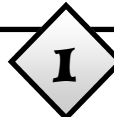
Do your gums ever bleed? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Soft Medium Hard



Use this area to tell us any other information about your medical/dental history or problems you may be having that are not explained elsewhere on this form.



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

Signature

Date