**Medical Alert:**

**PATIENT**

**REASON FOR TODAYS VISIT:** _____

(PLEASE PRINT) Mr./Mrs./Ms. (Circle one) Male _____ Female _____

PATIENT NAME: FIRST _____ MI ____ LAST _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (___)_____WORK PHONE (___)_____SSN #_____ -_____ -_____

E-MAIL _____ EMPLOYER _____

NAME OF PHYSICIAN & PHONE NO _____ DATE OF LAST PHYSICAL _____

***IN CASE OF EMERGENCY CONTACT*** _____ ***PHONE*** _____

## DO YOU HAVE A HISTORY OF:

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A.I.D.S/HIV Positive | ❑ | ❑ | Excessive Bleeding | ❑ | ❑ | Low Blood Pressure | ❑ | ❑ | Stroke | ❑ | ❑ |
| Alcoholism | ❑ | ❑ | Frequent Headaches | ❑ | ❑ | Malignancies | ❑ | ❑ | Tuberculosis | ❑ | ❑ |
| Allergies | ❑ | ❑ | Hearing Impaired | ❑ | ❑ | Neck & Back Problems | ❑ | ❑ | Ulcers | ❑ | ❑ |
| Anemia | ❑ | ❑ | Heart Disease | ❑ | ❑ | Nervous Problems | ❑ | ❑ | Venereal Disease | ❑ | ❑ |
| Arthritis | ❑ | ❑ | Heart Valve, Murmur | ❑ | ❑ | Pacemaker | ❑ | ❑ | Bone Disease | ❑ | ❑ |
| Asthma | ❑ | ❑ | Hepatitis/Liver Disease | ❑ | ❑ | Prosthetic Joints | ❑ | ❑ | Epilepsy | ❑ | ❑ |
| Cancer | ❑ | ❑ | Hepatitis Carrier | ❑ | ❑ | Psychiatric Care | ❑ | ❑ | Thyroid Disease | ❑ | ❑ |
| Chemical Dependency | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Radiation Treatments | ❑ | ❑ | | | |
| Chest Pain | ❑ | ❑ | Kidney Disease | ❑ | ❑ | Respiratory Problems | ❑ | ❑ | Are there any problems | | |
| Circulatory Problems | ❑ | ❑ | Kidney Dialysis | ❑ | ❑ | Rheumatic Fever | ❑ | ❑ | not listed you would like | | |
| Convulsions/Seizures | ❑ | ❑ | Latex Sensitivity | ❑ | ❑ | Scarlet Fever | ❑ | ❑ | to discuss? | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Lupus | ❑ | ❑ | Sinus Problems | ❑ | ❑ | | | |

List any medications you are taking including non-prescription drugs

1. _____
2. _____
3. _____
4. _____

Are you allergic to any medications?

1. _____
2. _____
3. _____
4. _____

## DENTAL INFORMATION

1. Date of last dental visit: _____
2. If wearing dentures, age of dentures: _____

| | YES | NO |
|---|---|---|
| 3. Do your gums bleed when brushing or eating? | ❑ | ❑ |
| 4. Do you ever clench or grind your teeth? | ❑ | ❑ |
| 5. Are your teeth sensitive to hot, cold or pressure? | ❑ | ❑ |

| **WOMEN** | YES | NO |
|---|---|---|
| Is there a possibility of pregnancy? | ❑ | ❑ |
| Estimated delivery date ____/____/____ | ❑ | ❑ |
| Are you nursing? | ❑ | ❑ |
| Are you taking birth control pills? | ❑ | ❑ |

***WOMEN NOTE:*** *Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynocologist for assistance regarding additional methods of birth control.*

On a scale of 1 to 10 with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

| If I could change my smile I would make my teeth: | YES | NO |
|---|---|---|
| Whiter | ❑ | ❑ |
| Straighter | ❑ | ❑ |
| Close space | ❑ | ❑ |
| Replace black mercury fillings with tooth colored restorations | ❑ | ❑ |
| Repair chipped teeth | ❑ | ❑ |
| Replace missing teeth | ❑ | ❑ |
| Less gum showing | ❑ | ❑ |
| Replace old crowns or caps that don't match | ❑ | ❑ |
| Do you prefer to save your teeth? | ❑ | ❑ |

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors that I have made in the completion of this form.

Signature of Patient (parent or guardian if minor): _____ Date _____

Health History Reviewed by: _____ Dentist Signature: _____