

Medical Alert: _____

REASON FOR TODAY'S VISIT: _____

PATIENT

(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	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Are there any problems		
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	not listed you would like		
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	to discuss?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>			

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you ever clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are your teeth sensitive to hot, cold or pressure? | <input type="checkbox"/> | <input type="checkbox"/> |

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Straighter | <input type="checkbox"/> | <input type="checkbox"/> |
| Close space | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace black mercury fillings with tooth colored restorations | <input type="checkbox"/> | <input type="checkbox"/> |
| Repair chipped teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace missing teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| Less gum showing | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace old crowns or caps that don't match | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you prefer to save your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

WOMEN

- | | YES | NO |
|--|--------------------------|--------------------------|
| Is there a possibility of pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Estimated delivery date ____/____/____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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: _____