

**MEDICAL HISTORY**

Date: \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_

Physician \_\_\_\_\_ Office Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_/\_\_\_/\_\_\_

1. Are you under medical treatment now? YES NO

2. Are you taking any medication(s) including non-prescription medicine? YES NO

If Yes, what medication(s) are you taking? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Do you use tobacco? YES NO

4. Do you wear contact lenses? YES NO

5. Are you allergic to or have you had any reactions to any drugs? If yes, please specify.

\_\_\_ No known allergies  
YES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Women only:

A) Are you pregnant or think you might be pregnant? YES NO

B) Are you nursing? YES NO

C) Are you taking birth control pills? YES NO

Please indicate which of the following applies to you. Check only if answer is yes.

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Eating Disorder                           | <input type="checkbox"/> Hepatitis: A B or C          |
| <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Anemia                                    | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Fainting/Seizures    | <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Aids or HIV Infection        |
| <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Emphysema                                 | <input type="checkbox"/> Cancer                       |
| <input type="checkbox"/> Heart Trouble         | <input type="checkbox"/> Leukemia             | <input type="checkbox"/> Tuberculosis                              | <input type="checkbox"/> Radiation Therapy            |
| <input type="checkbox"/> Cardiac Pacemaker     | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Respiratory Problems                      | <input type="checkbox"/> Stomach Trouble/Ulcers       |
| <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Mental Disorder      | <input type="checkbox"/> Hay Fever / Allergies                     | <input type="checkbox"/> Other:                       |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problem      | <input type="checkbox"/> Asthma                                    |   |
| <input type="checkbox"/> Angina                | <input type="checkbox"/> Kidney Diseases      | <input type="checkbox"/> Joint Replacement or Implant Where? _____ |   |
| <input type="checkbox"/> Chest Pains           |   |  |   |

Comments: \_\_\_\_\_

**DENTAL HISTORY:**

Previous Dentist: \_\_\_\_\_ Last Dental Visit: \_\_\_/\_\_\_/\_\_\_

Reason for changing: \_\_\_\_\_

Please answer the following questions with a "Y" for yes or "N" for no.

- |   |   |
|---|---|
| <input type="checkbox"/> Do your gums bleed while brushing or flossing?                       | <input type="checkbox"/> Have you ever had any difficult extractions in the past?   |
| <input type="checkbox"/> Are your teeth sensitive to hot or cold liquids/foods?               | <input type="checkbox"/> Have you had orthodontic work?   |
| <input type="checkbox"/> Are your teeth sensitive to sweet or sour liquids/foods?             | <input type="checkbox"/> Have you had prolonged bleeding following extractions?   |
| <input type="checkbox"/> Do you feel pain to any of your teeth?                               | <input type="checkbox"/> Do you have <b>extreme</b> anxiety about dental procedures?  |
| <input type="checkbox"/> Do you have any sores or lumps in or near your mouth?                | <input type="checkbox"/> Have you experienced difficulty becoming numb for dental procedures?   |
| <input type="checkbox"/> Have you had any head, neck or jaw injuries?                         | <input type="checkbox"/> Have you had instructions on the care of your gums?  |
| <input type="checkbox"/> Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> Have you ever had instruction on the correct method of brushing of your teeth?   |
| <input type="checkbox"/> Clicking?  | <input type="checkbox"/> Do you use an electric toothbrush? Model? _____  |
| <input type="checkbox"/> Pain (Joint, Ear, Side of face)?                                     | <input type="checkbox"/> Are you satisfied with the appearance of your teeth?   |
| <input type="checkbox"/> Difficulty in opening or closing?                                    | <input type="checkbox"/> Are you interested in learning more about Zoom!, an in-office whitening procedure, as seen on ABC's hit show <i>Extreme Makeover</i> ? |
| <input type="checkbox"/> Difficulty in chewing?   |   |
| <input type="checkbox"/> Do you have frequent headaches?                                      |   |
| <input type="checkbox"/> Do you clench or grind your teeth?                                   |   |
| <input type="checkbox"/> Do you bite your lips or cheeks frequently?                          |   |

I certify that I have read and understand the above information, and to the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X \_\_\_\_\_  
Guest, Parent or Guardian

Date \_\_\_/\_\_\_/\_\_\_