Confidential Medical /Dental History

Name_____Date of Birth_____
Home #_____Work #_____Cell #_____

What is your physician's name? _____Phone #_____
Are you allergic to any of the following:
Penicillin ____ Yes ____No Gluten ___Yes ___No Red Food Dye ___Yes ___No
Dental Anesthetics ___Yes ___No LATEX ___Yes ___No
Are you allergic to any medication? ___Yes ___No
If yes, please list: _____
Have you had excessive bleeding requiring special treatment? ___Yes ___No
If yes, explain: _____
Have you been under a physician's care during the past two years? ___Yes ___No
If yes, please give reason: _____
Are you taking any kind of medicine or drugs now? ___Yes ___No
If yes, please list: _____
Have you been a patient in the hospital in the last five years? ___Yes ___No
If so, please explain: _____
Have you traveled outside the US in the last year? ___Yes ___No Have you ever been exposed to tuberculosis? ___Yes ___NO
WOMEN – Are you pregnant? ___Yes ___NO Are you nursing? ___ Yes ___NO

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE OR HAVE HAD:

___AIDS or HIV Infection	___Sinus Trouble	___Heart Trouble	___High Blood Pressure
___Hepatitis	___Asthma	___Artificial Heart Valve	___Arthritis
___Venereal Disease	___Rheumatic Fever	___Heart Lesion	___Hearing Loss
___Herpes	___Cancer	___Heart Murmur	___Epilepsy/Seizures
___Jaundice	___Diabetes	___Stroke	___Anemia
___Persistent Cough	___ Tuberculosis	___Cardiac Pacemaker	___Autoimmune Disease
___Emphysema	___ Metal Rods/Screws/Plates	___Artificial Bone/Joints/Implants	

Do you grind or clench your teeth? ___Yes ___No
Have or had canker/cold sores? ___Yes ___No
Have you ever had any trouble with previous dental treatment? ___ Yes ___No
Do your teeth feel sore when you bite on them? ___Yes ___No
Do hot, cold, or sweet beverages cause discomfort or pain in your mouth? ___Yes ___No
Do you have lumps or sores in your mouth? ___Yes ___No
Do you smoke or use smokeless tobacco? ___Yes ___No If yes, how much? _____
Do you have history of periodontal disease or have you had treatment for periodontal disease? ___Yes ___No

When was the last time you saw a dentist? _____Dentist Name_____
Are you happy with your smile? ___Yes ___No What would you change? _____
Reason for today's visit: _____
Did someone refer you to our office? ___Yes ___No Who may we thank? _____

ACKNOWLEDGMENT AND AUTHORITY:
I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to any drugs, medicine, performance of operations and conduct of laboratory, x-ay, or studies that may be used by the attending dentist, or his/her hygienist, or qualified designate.

Signed_____ Date_____
Patient, Parent or Agent (must be 18 years or older)