Patient Name:_____

MEDICAL-DENTAL HISTORY

Do you have/have had any of the following:

☐	Anemia	☐	Heart Disease
☐	Angina	☐	Heart Surgery
☐	Arthritis/Rheumatism	☐	Hepatitis or Jaundice
☐	Artificial Joints	☐	High Blood Pressure
☐	Asthma	☐	HIV/AIDS
☐	Autoimmune Disease	☐	Kidney Disease
☐	Blood Disease	☐	Liver Disease
☐	Cancer or Tumors	☐	Low Blood Pressure
☐	Chemotherapy or Radiation	☐	Psychological Conditions
☐	Cholesterol	☐	Neurological Concerns
☐	Diabetes	☐	Osteoporosis
☐	Dizziness/Fainting	☐	Pacemaker
☐	Eating Disorder	☐	Premedication (Joint Replacement/Heart Condition)
☐	Endocarditis	☐	Respiratory Problems
☐	Enlarged Lymph Nodes	☐	Sleep Apnea
☐	Epilepsy or Seizures	☐	Slow Healing Sores
☐	Excessive Bleeding	☐	Stomach Problems
☐	Glaucoma	☐	Stroke
☐	Hay Fever/Allergies/Sinusitis	☐	Substance Abuse
☐	Head Injuries	☐	Thyroid Disease
☐	Hearing Concerns	☐	Tuberculosis
☐	Heart Attack	☐	Herpes Virus/Cold Sores

Please check if allergic/sensitive/or have had adverse reactions to:

- ☐ **Penicillin or Amoxicillin**
- ☐ **Other Antibiotics_____**
- ☐ **Latex**
- ☐ **Local Anesthetic**
- ☐ **Other Medication/Substances**
- ☐ **Codeine / Valium / Other Sedatives**
- ☐ **Aspirin / Tylenol / Ibuprofen**
- ☐ **NONE**

Women:

- ☐ **Birth Control Pills**
- ☐ **Pregnant/Trying to get pregnant**
- ☐ **Nursing**

Have you ever been treated with Bisphosphonate Drugs? (ex.: Fosamax, Boniva, Actonel; for Osteoporosis, Paget's or Cancer)

- ☐ **Yes**
- ☐ **No**

Have you had a serious illness, operation, or hospitalization in the past 5 years?

- ☐ Yes _____
- ☐ No

Do you use tobacco:

- ☐ Yes, Type (smoke, chew, pipe)?_____
  How much/day?_____
  For how many years?_____
- ☐ No

Are you under the care of a physician?

- ☐ Yes, Reason:_____
- ☐ No

Date of last healthcare exam: _____

Physician's Name:_____

Address:_____

Phone Number:_____

Do you consume alcohol:

- ☐ Yes (how many beverages/week?)_____
- ☐ No

Do you use any mood-altering drugs other than previously listed?

- ☐ Yes (Name)_____
- ☐ No

Is Pre-Medication Required? YES / NO

What is your normal Blood Pressure: _____/_____

For Office Use:

Blood Pressure: _____/_____
Pulse: _____

Patient Name:_____

Please list all medications (prescription, vitamins, herbal supplements, OTC taken routinely: (Please include dosages, if possible, and reason for taking) Are you taking blood thinners? ☐ Yes ☐ No	

Please check any of the following conditions that apply to you:

☐ Bleeding, swollen or irritated gums ☐ Periodontal/gum disease ☐ Bad breath ☐ Loose, tipped, shifting teeth ☐ Sensitivity to cold, hot or sweet ☐ Pressure tenderness, biting sensitivity ☐ Broken teeth/fillings ☐ Headaches ☐ Jaw joint (TMJ) pain	☐ Jaw joint (TMJ) clicking/popping ☐ Difficulty opening or closing ☐ Grinding or Clenching ☐ Sore muscles (head/neck/shoulders) ☐ History of head/jaw/tooth trauma ☐ Bad bite ☐ Worn teeth/flat teeth ☐ Crooked teeth	☐ Spaces ☐ Misshaped teeth ☐ Mouth Breathing ☐ Dry mouth ☐ Difficulty chewing on either side ☐ Discolored Teeth ☐ Noise sensitivity ☐ Bad dental experiences ☐ Anxiety/fear (dentists, needles, etc.)

On a scale of 1-10, with 10 being the highest rating, rate your smile:
Rate where you would like your smile to be on the scale:
What would you like to change about your smile:

- ☐ Color / Whiter teeth
- ☐ Replacement of missing teeth
- ☐ Crowding / Spacing
- ☐ Bite
- ☐ Smile makeover

Date of last dental cleaning:
Date of last Oral Cancer Screening:
Date of last dental exam:
Date of last complete x-rays (Full Mouth Series):
Name and Phone number of previous dentist:

Why did you leave previous dentist?

I certify the answers given are true and complete to the best of my knowledge.

Signature_____ Date: _____