



PATIENT'S NAME \_\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Last M / F Chart Number: \_\_\_\_\_ First Initial

**Medical History**

Are you currently seeing a physician for a health issue ? YES / NO  
 Name of primary physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 List all current prescription medications: \_\_\_\_\_  
 \_\_\_\_\_  
 List any vitamins or supplements you are taking: \_\_\_\_\_  
 Have you ever used Phen Fen or other weight loss drugs? YES / NO Which: \_\_\_\_\_  
 Have you ever had major surgery? YES / NO Type of surgery: \_\_\_\_\_

**Are you allergic to or have you had an adverse reaction to any of the following:**  
 Local Anesthetic Penicillin Erythromycin Codeine Latex Metals  
 Other: \_\_\_\_\_

**Circle any of the following you have had:**

AIDS / ARC / HIV +	Chemotherapy	Heart surgery	Respiratory disease
Anaphylaxis	Circulatory problems	Hemophilia	Rheumatic fever
Anemia	Cortisone treatments	Herpes	Shingles
Angina	Cough, persistent	Hepatitis	Shortness of breath
Anorexia/ Bulimia	Cough up blood	High blood pressure	Skin rash
Arthritis / Rheumatism	Diabetes	Jaw pain	Stroke
Artificial heart valve	Epilepsy / Seizures	Kidney disease	Swelling of feet or ankles
Artificial joints	Fainting	Liver disease	Tuberculosis (TB)
Asthma	Food Allergy	Mitral valve prolapse	Thyroid disease
Back problems	Glaucoma	Pacemaker	Tonsillitis
Blood disease	Headaches	Psychiatric condition	Ulcer / Colitis
Cancer	Heart attack or disease	Rapid weight gain or loss	Venereal disease
Chemical dependency	Heart murmur	Radiation	Other

**Women:** Are you pregnant YES / NO Nursing YES / NO Taking birth control pills YES / NO

**Tobacco use:** cigarettes pipe cigar chew non-smoker  
 How much: \_\_\_\_\_ How often: \_\_\_\_\_

**Dental History**

How can we help you today: \_\_\_\_\_  
 When were you last seen by a dentist? \_\_\_\_\_ Why: \_\_\_\_\_  
 Date of most current x-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name of prior dentist: \_\_\_\_\_ Phone \_\_\_\_\_  
 Address: \_\_\_\_\_  
 How often do you: brush \_\_\_\_\_ floss \_\_\_\_\_ rinse \_\_\_\_\_

**Circle any of the following that apply:**

Bad breath	Crowded or crooked teeth	Grinding or clenching habit
Bleeding or sore gums	Discolored teeth	Loose teeth
Broken fillings	Food collection between teeth	Missing teeth
Clicking or popping jaw	Facial pain	Poor fitting denture or other appliance

**Circle dental services you have previously received:**

Braces	Dentures / Partials	Gum surgery	Tooth whitening
Bridges	Extractions	Implants	Veneers
Crowns	Fillings	Root canal	Other

Do any of your teeth have prolonged sensitivity to: Hot Cold Sweets Biting pressure  
 Have you ever been told to take antibiotic pre-medication before dental treatment: YES / NO  
 Have you had complications with previous dental treatment? YES / NO  
 If so please explain: \_\_\_\_\_  
 Is there anything about dentistry you strongly dislike? \_\_\_\_\_

Do you have any other concerns or is there anything else we have not covered?  
 \_\_\_\_\_

*I certify that the above information is accurate and complete*  
 Patients signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dentist signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_