## Medical History

Physicians Name ______________________________ Phone ______________

| | Yes | No | | |
|---|---|---|---|---|
| 1. Are you currently under medical treatment? | ☐ | ☐ | Explain | ______________ |
| 2. Ever had any serious illness or operations? | ☐ | ☐ | Explain | ______________ |
| 3. Are you currently taking any medications? | ☐ | ☐ | Please list | ______________ |
| 4. Have you ever taken Phen-Fen / Redux? | ☐ | ☐ | | |

5. Have you had any allergic reactions to the following?

| | | |
|---|---|---|
| ☐ Local anesthetics | ☐ Penicillin | ☐ Sulfa drugs |
| ☐ Sedatives | ☐ Aspirin | ☐ Latex |
| ☐ Codeine | ☐ Other | ______________ |

6. Women are you: ☐ Pregnant ☐ Nursing ☐ Taking birth control

Do you have or ever had any of the following:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| AIDS | ☐ | ☐ | Headaches | ☐ | ☐ | Respiratory Disease | ☐ | ☐ |
| Anemia | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Heart Attack, Date _____ | ☐ | ☐ | Scarlet Fever | ☐ | ☐ |
| Artificial Heart Valves | ☐ | ☐ | Hepatitis, Type ___ | ☐ | ☐ | Shortness of Breath | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ | Herpes | ☐ | ☐ | Sinus Trouble | ☐ | ☐ |
| Asthma | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Stroke, Date _____ | ☐ | ☐ |
| Blood Disease | ☐ | ☐ | HIV Positive | ☐ | ☐ | Swelling Feet/Ankles | ☐ | ☐ |
| Cancer | ☐ | ☐ | Jaundice | ☐ | ☐ | Swollen Neck Glands | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ | Jaw Pain/Clicking | ☐ | ☐ | Teeth Grinding | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Thyroid Problems | ☐ | ☐ |
| Congenital Heart Lesions | ☐ | ☐ | Liver Disease | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Ulcer | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Pacemaker | ☐ | ☐ | | | |
| Fainting/Dizziness | ☐ | ☐ | Radiation Treatment | ☐ | ☐ | | | |

## Dental History

Reason for today's visit? ______________________________

Former Dentist ______________ Date of last x-rays? ______________

City, State ______________ How often do you floss? ______________

Date of last dental visit ______________ How often do you brush? ______________

Would you be interested in any of the following?

Teeth Whitening ☐ Snore Guard ☐ Night Guard ☐

Porcelain Veneers ☐

The answers I have provided above accurately summarize my past and present medical health condition(s) and all of the prescription medications which I currently take.

______________________________ ______________

Patient (parent/guardian) Signature Date