

Special Interests, Sports or Hobbies: \_\_\_\_\_

### Dental History

Why have you come to the dentist today? \_\_\_\_\_

Your current dental health is:  Good  Fair  Poor

Do you grind or clench your teeth?  Yes  No Are you troubled with bad breath?  Yes  No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)  Yes  No

On a scale of 1 to 10, with 10 being very severe, what is your level of anxiety while visiting a dental office? \_\_\_\_\_

Do you play sports?  Yes  No If yes, do you wear a mouthguard?  Yes  No

What, if anything, about your smile would you like to change: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Last visit date: \_\_\_\_\_

### Medical History

Are you currently under the care of a physician?  No  Yes Name of Physician: \_\_\_\_\_

If yes, please explain. \_\_\_\_\_

Please list all prescription, vitamins, herbs and/or over the counter drugs, that you take regularly: \_\_\_\_\_

Are you taking birth control pills?  Yes  No Are you Pregnant?  Yes  No Week # \_\_\_\_\_

Are you nursing?  Yes  No

Have you had any of the following diseases or medical problems? (PLEASE CIRCLE Y or N)

Y N Abnormal Bleeding	Y N Fainting Spells	Y N Lupus
Y N Alcohol Abuse	Y N Fever Blisters	Y N Mitral Valve Prolapse
Y N Anemia	Y N Glaucoma	Y N Pacemaker
Y N Artificial Bones/Joints	Y N Hay Fever	Y N Persistent Cough
Y N Asthma	Y N Headaches	Y N Psychiatric Problems
Y N Blood Transfusion	Y N Heart Murmur	Y N Radiation Treatment
Y N Cancer	Y N Heart Surgery	Y N Rheumatic Fever
Y N Chemotherapy	Y N Hemophilia	Y N Scarlet Fever
Y N Chicken Pox	Y N Hepatitis	Y N Seizures
Y N Colitis	Y N Herpes	Y N Shingles
Y N Congenital Heart Defect	Y N High Blood Pressure	Y N Sickle Cell Disease
Y N Diabetes	Y N HIV+/ AIDS	Y N Sinus Problems
Y N Difficulty Breathing	Y N Hospitalized for any reason	Y N Stroke
Y N Drug Abuse	Y N Kidney Problems	Y N Thyroid Problems
Y N Emphysema	Y N Liver Disease	Y N Tuberculosis (TB)
Y N Epilepsy	Y N Low Blood Pressure	Y N Ulcers
	Y N Other _____	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: \_\_\_\_\_

Have you ever been told that you need to premedicate prior to dental appointments:  Yes  No

Do you know of any allergies to the following: (PLEASE CIRCLE Y or N)

Y N Aspirin	Y N Erythromycin	Y N Jewelry/Metals	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Penicillin	Y N Dental Anesthetics
Y N Barbiturates	Y N Sedatives	Y N Sulfa Drugs	

Please list any other drug that you are allergic to: \_\_\_\_\_

Have you ever taken Phen-Fen, Redux or Pondimin?  Yes  No

Do you smoke?  Yes  No Do you use any other tobacco product?  Yes  No

**PLEASE INFORM US OF ANY CHANGES IN YOUR MEDICAL STATUS WHICH MIGHT OCCUR DURING THE COURSE OF YOUR CARE IN OUR PRACTICE.**

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date