Medical & Dental History

Patient Name: _____ Date of Birth: _____

Dental History

1. When did you last see a dentist _____ What treatment was performed? _____
2. Do you grind or clench your teeth, experience clicking or popping in the ear or jaw joint, or been diagnosed with TMJ problems? ○ Yes ○ No If yes please specify:_____
3. Do you frequently have bad breath? ○ Yes ○ No Do your gums bleed easily? ○Yes ○No
4. Do you wish your teeth were lighter in color? ○ Yes ○ No Are you satisfied with the look of your teeth? ○ Yes ○ No
5. Do you floss your teeth? ○ Yes ○ No If so how often do you floss? _____
6. Please list any medications you are presently taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____

7. Please list any medications you are allergic to _____

Medical History

Please check "Yes" or "No" if you have had or presently have any of the following conditions

Are you presently being treated by a physician? If yes, please explain: _____

AIDS/HIV+	Yes ◯ No ◯	Heart Murmur	Yes ◯ No ◯
Anemia	Yes ◯ No ◯	Heart pacemaker	Yes ◯ No ◯
Arthritis	Yes ◯ No ◯	Hemophelia	Yes ◯ No ◯
Artificial heart valve	Yes ◯ No ◯	Hepatitis (A, B, or C)	Yes ◯ No ◯
Asthma	Yes ◯ No ◯	Herpes (cold sores)	Yes ◯ No ◯
Bisphosphonate therapy	Yes ◯ No ◯	High blood pressure	Yes ◯ No ◯
Bleeding problems	Yes ◯ No ◯	Joint replacement	Yes ◯ No ◯
Cancer	Yes ◯ No ◯	Mitral valve prolapse	Yes ◯ No ◯
Chemo/ radiation therapy	Yes ◯ No ◯	Oral contraceptives	Yes ◯ No ◯
Chest pains	Yes ◯ No ◯	Osteoporosis	Yes ◯ No ◯
Congenital heart condition	Yes ◯ No ◯	Pregnant or nursing	Yes ◯ No ◯
Diabetes	Yes ◯ No ◯	Rheumatic fever	Yes ◯ No ◯
Drug addiction	Yes ◯ No ◯	Sickle cell disease	Yes ◯ No ◯
Emphysema	Yes ◯ No ◯	Sleep apnea	Yes ◯ No ◯
Epilepsy or convulsions	Yes ◯ No ◯	Stroke	Yes ◯ No ◯
Genital herpes	Yes ◯ No ◯	Tobacco use	Yes ◯ No ◯
Glaucoma	Yes ◯ No ◯	Tuberculosis	Yes ◯ No ◯
Heart attack/surgery	Yes ◯ No ◯	Tumors	Yes ◯ No ◯
Heart condition or problems	Yes ◯ No ◯	Venereal disease	Yes ◯ No ◯

To the best of my knowledge the questions on this form have been accurately answered. I understand it is my responsibility to inform the dentist of any changes to my medical status.

Patient or guardian's signature _____ Date: _____

Medical History Update:

1. Patient or guardian's signature _____ Date: _____
2. Patient or guardian's signature _____ Date: _____
3. Patient or guardian's signature _____ Date: _____
4. Patient or guardian's signature _____ Date: _____