

PLEASE PRINT

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

IN CASE OF EMERGENCY CALL: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Physician's name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

**MEDICAL HISTORY**

Please CIRCLE the conditions below if you CURRENTLY HAVE or HAVE HAD them in the past.

|                         |                         |                              |
|-------------------------|-------------------------|------------------------------|
| BEHAVIOR PROBLEMS       | ARTHRITIS               | RADIATION TREATMENT          |
| COMMUNICATION PROBLEMS  | ANEMIA                  | CHEMOTHERAPY                 |
| SEIZURES                | EXCESSIVE BLEEDING      | SEXUALLY TRANSMITTED DISEASE |
| FAINTING                | BLOOD DISORDER          | AIDS OR ARC                  |
| LOSS OF CONSCIOUSNESS   | TRANSFUSIONS            | ORAL HERPES                  |
| HEARING OR SIGHT LOSS   | ASTHMA                  | SICKLE CELL DISEASE          |
| HEART DISEASE OR ATTACK | SHORTNESS OF BREATH     | TUBERCULOSIS (TB)            |
| STROKE                  | RESPIRATORY DISORDERS   | STOMACH DISORDER             |
| RHEUMATIC FEVER         | SINUS PROBLEMS          | THYROID DISEASE              |
| HEART MURMUR            | LIVER DISORDER          | DIABETES                     |
| MITRAL VALVE PROLAPSE   | HEPATITIS - TYPE _____  | CANCER - TYPE _____          |
| HIGH BLOOD PRESSURE     | KIDNEY PROBLEMS         | DIET DRUGS - NAME _____      |
| ARTIFICIAL HEART VALVE  | STEROID THERAPY         |                              |
| PACEMAKER               | REACTION TO ANESTHETICS |                              |

Are you ALLERGIC to any MEDICATIONS or LATEX or METALS? If yes, please list \_\_\_\_\_

Are you currently TAKING any MEDICATIONS? If yes, please list \_\_\_\_\_

Have you ever been HOSPITALIZED? If yes, please list: \_\_\_\_\_

Reason: \_\_\_\_\_ Date \_\_\_\_\_ Reason: \_\_\_\_\_ Date \_\_\_\_\_  
 Reason: \_\_\_\_\_ Date \_\_\_\_\_ Reason: \_\_\_\_\_ Date \_\_\_\_\_

WOMEN-Are you or could you be PREGNANT? \_\_\_\_\_ Due Date: \_\_\_\_\_

**DENTAL HISTORY**

Reason for today's visit? \_\_\_\_\_  
 Are you in any pain? \_\_\_\_\_  
 Last dental visit? \_\_\_\_\_  
 Name of previous dentist? \_\_\_\_\_  
 Are you happy with the appearance of your teeth? \_\_\_\_\_  
 Do you feel you have bad breath? \_\_\_\_\_  
 Are you apprehensive of dental treatment? \_\_\_\_\_  
 Do you smoke or chew tobacco? \_\_\_\_\_  
 Have you ever been told you have gum disease? \_\_\_\_\_  
 Do your gums bleed when you brush? \_\_\_\_\_  
 Update: \_\_\_\_\_

I understand the information I provide on this form is essential to determine my dental needs and the provision of dental treatment. I understand that if any change occurs in my health I am to report it to the dental office as soon as possible. I have read, and understand each question, and have answered all of them truthfully and to the best of my ability. I have discussed my health history with the doctor.

Signature \_\_\_\_\_

**MEDICAL/DENTAL HISTORY**

\*This MUST be signed and dated by the patient unless a minor, or patient has legal guardian. then parent or legal guardian must sign and date. Your signature indicates that the information is current and accurate.

UPDATED PATIENT INFORMATION AND ASSIGNMENT:

Signature \_\_\_\_\_ Date \_\_\_\_\_

UPDATED PATIENT INFORMATION AND ASSIGNMENT:

Signature \_\_\_\_\_ Date \_\_\_\_\_

UPDATED PATIENT INFORMATION AND ASSIGNMENT:

Signature \_\_\_\_\_ Date \_\_\_\_\_