Office Use Only-

Hyg/Team: _____

Ins/Coupon: _____

Comfort Menu: _____

Medical History

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List any medications that you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
□	□	Anesthetic	□	□	Iodine
□	□	Aspirin	□	□	Latex
□	□	Codeine	□	□	Penicillin
□	□	Ibuprofen	□	□	Sulfa

Other Allergies: _____

Do you have any of the following medical conditions?

Y	N		Y	N	
□	□	Asthma	□	□	Kidney Disease
□	□	Abnormal Bleeding	□	□	Liver Disease
□	□	Cancer	□	□	Pregnant/Nursing
□	□	Diabetes Type I or II	□	□	Depression/Anxiety
□	□	Heart Attack	□	□	Sinus Trouble
□	□	Heart Trouble	□	□	Stroke
□	□	High Blood Pressure	□	□	Ulcers
□	□	Joint Replacement	□	□	Drug/Alcohol Abuse
□	□	Hyperthyroidism	□	□	Hypothyroidism
□	□	Anemia	□	□	Severe/Frequent Headaches/Migraines
□	□	Dementia/Alzheimer's	□	□	Tuberculosis
□	□	Fever Blisters/Cold Sores	□	□	Snoring
□	□	Epilepsy/Seizures/Fainting Spells	□	□	Sleep Apnea
□	□	Pacemaker	□	□	Glaucoma
□	□	Hepatitis A/B/C	□	□	Macular Degeneration
□	□	HIV/AIDS	□	□	Blood Transfusion
□	□	Head/Neck Radiation Treatment	□	□	Transplant
□	□	Anorexia/Bulimia	□	□	Heart Valve Replacement
□	□	Acid Reflux/Persistent Heartburn	□	□	Do you require an antibiotic for dental work?

Past surgical history: _____

Dental History

Y N
□ □ Do you require antibiotics before dental treatment?
□ □ Do you have dry mouth?
□ □ Do your gums bleed?
□ □ Have you ever had periodontal (gum) treatment?
□ □ Have you ever had orthodontic (braces) treatment?
□ □ Have you ever participated in a sleep study?
□ □ Have you ever been treated for TMJ problems?
□ □ Do you smoke or use tobacco?
□ □ Have you ever taken Fosamax, Actonel, or Boniva?

How many times per day do you brush your teeth? _____

How many times a week do you floss your teeth? _____

Have you ever had an unusual reaction to dental injections? _____

Has anyone ever told you that you grind your teeth? _____

Do you have any history of dental anxiety? _____

Is there anything you would like to change about your smile? _____

_____

_____

Is there anything else you think we should know that hasn't been addressed? _____

_____

_____

_____ _____

Signature of Patient, Parent, or Guardian Date