MEDICAL/DENTAL HISTORY

NAME _____ DATE _____

1. Are you having any dental problems at this time? ..... ❑ NO ❑ YES

2. Do you feel nervous about having dental treatment? ..... ❑ NO ❑ YES
   If yes, care to elaborate? _____
   _____

3. Do you floss every day? ..... ❑ NO ❑ YES
   Do your gums bleed? ..... ❑ NO ❑ YES

4. How do you feel about the appearance of your smile and your teeth in general?
   Feel free to elaborate _____
   _____
   _____

5. Check any of the following that you have currently or in the past:

- ❑ Heart Disease or Attack
- ❑ Angina Pectoris (chest pain)
- ❑ High Blood Pressure
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Congenital Heart Problems
- ❑ Scarlet Fever
- ❑ Mitral Valve Prolapse
- ❑ Artificial Heart Valve
- ❑ Heart Pacemaker
- ❑ Heart Surgery
- ❑ Artificial Joint
- ❑ Anemia
- ❑ Stroke
- ❑ Kidney Trouble
- ❑ Kidney Shunts
- ❑ Ulcers
- ❑ Allergic to:
  - ❑ Penicillin
  - ❑ Aspirin
  - ❑ Codeine
- ❑ Shortness of Breath
- ❑ Emphysema
- ❑ Cosmetic Surgery
- ❑ Cancer or Tumor
- ❑ Tuberculosis (TB)
- ❑ Asthma
- ❑ Hay Fever
- ❑ Allergies or Hives
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ X-Ray or Cobalt Treatment for Cancer
- ❑ Chemotherapy (Cancer, Leukemia)
- ❑ Arthritis
- ❑ Rheumatism
- ❑ Cortisone Medication
- ❑ Pain in Jaw Joints
- ❑ Hepatitis A (infectious)
- ❑ Hepatitis B (serum)
- ❑ Hepatitis C
- ❑ Liver Disease or Jaundice
- ❑ Blood Transfusion
- ❑ Hemophilia
- ❑ Venereal Disease
- ❑ Cold Sores or Fever Blisters
- ❑ Epilepsy or Seizures
- ❑ Fainting or Dizzy Spells
- ❑ Nervousnes
- ❑ Psychiatric Treatment
- ❑ Sickle Cell Disease
- ❑ Bruise Easily
- ❑ Abnormal Bleeding
- ❑ Pregnant
- ❑ Due Date _____
- ❑ HIV Positive
- ❑ AIDS
- ❑ Tobacco use
  - How long? _____
  - Type _____

6. Have you ever been under the care of a medical doctor and/or hospitalized during the past two years? ..... ❑ NO ❑ YES
   If so, for what reason? _____

7. Are you allergic to or made sick by any drugs or medications? ❑ NO ❑ YES
   If so, please list: _____

8. If you have any disease, condition or problem not listed, describe: _____
   _____

9. List all medications you are taking at this time: (include birth control) _____
   _____
   _____

Signature _____