PATIENT MEDICAL INFORMATION ***Patient Name _____***

Name of Physician _____ Telephone # _____ Last Exam _____
Are you under medical care at this time? _____
(If yes to any of the following please explain)
Have you been hospitalized within the last 5 years? _____
Please list any medications you are taking, including non-prescribed medications? _____
_____
Are you wearing contact lenses? _____ Do you use any controlled substances? _____
Do you use tobacco products? _____ What type? _____ How often?_____
Have you ever taken Phen-Fen/Redux? _____ When? _____ For how Long? _____
Are you or have you ever taken? Fosamax _____ Actenol _____ Zometa _____ Aredia _____ Boniva _____
***WOMEN ONLY**: Are you pregnant? (or think you may be) _____ How far along are you? _____*
Are you nursing? _____ Are you taking oral contraceptives? _____
ALLERGIES: Are you allergic or have any reaction to the following:
Local Anesthetic (Novocain) _____ Penicillin or any other Antibiotics _____
Latex Rubber____ Aspirin _____ Barbituates _____ Sedatives _____ Sulfa Drugs _____ Codeine _____
Any Metals (Nickel, mercury, etc) _____ other _____
HAVE YOU HAD ANY OF THE FOLLOWING: Please check those that apply

____ *AIDS*	____ *Glaucoma*	____ *Radiation Treatment*
____ *Anemia*	____ *Heart Murmur*	____ *Respiratory Problems*
____ *Arthritis*	____ *Heart Disease*	____ *Rheumatic Fever*
____ *Artificial Joints*	____ *Head Injuries*	____ *Rheumatism*
____ *Asthma*	____ *Hepatitis*	____ *Sinus Problems*
____ *Angina*	____ *High Blood Pressure*	____ *Stomach Problems/Ulcers*
____ *Cancer*	____ *Heart Attack*	____ *Stroke*
____ *Cardiac Pacemaker*	____ *Jaundice*	____ *Sexually Transmitted Diseases*
____ *Chest Pains*	____ *Kidney Disease*	____ *Tuberculosis*
____ *Diabetes*	____ *Leukemia*	____ *Tumors*
____ *Dizziness*	____ *Low Blood Pressure*	____ *Thyroid Problems*
____ *Epilepsy*	____ *Liver Disease*	*Other:*
____ *Excessive Bleeding*	____ *Mental Disorders*	_____
____ *Emphysema*	____ *Mitral Prolapse Valve*	_____
____ *Fainting*	____ *Nervous Disorders*	_____

DENTAL HISTORY:

1. *Do you bleed while brushing or flossing? _____*
2. *Are your teeth sensitive to temperature? _____*
3. *Are your teeth sensitive to sweets? _____*
4. *Do you feel pain on any of your teeth?_____*
5. *Do you have any sores in or near your mouth? _____*
6. *Have you ever had any head, neck or jaw injuries? _____*
7. *Do you bite your lips or cheeks frequently? _____*
8. *Do you wear dentures or partials? _____*
9. *Are you nervous about dental treatment? _____*
10. *Do you have difficulty chewing?_____*
11. *Have you ever had orthodontic treatment? _____*
12. *Do you like your smile? _____*

I certify that to the best of my knowledge the information provided is accurate and correct. It is my responsibility to notify my doctor in case of any changes in my health history. I give consent for treatment.

_____ _____
Patient (Guardian if under age 18) *(Date)*

_____
Reviewed By *Date*