***Complete form digitally and then print to circle Yes/No questions*

DENTAL INFORMATION

Yes / No Do you have bleeding or sore gums? Yes / No Do you grind or clench your teeth? Yes / No Do you notice jaw clicking or popping?
Yes / No Any swelling or lumps in your mouth? Yes / No Are your teeth sensitive to hot or cold? Yes / No Are your teeth sensitive to pressure?
Yes / No Are your teeth sensitive to sweets? Yes / No Do you have any fear of dental treatment?

Date of last dental exam _____ Last Full Mouth X-rays taken _____

Previous Dentist _____

Reason for today's visit _____

What concerns do you currently have about your oral health or appearance of your teeth? _____

MEDICAL INFORMATION

Have you been a patient in the hospital during the past two years? Yes / No
Have you been under the care of a medical doctor during the past two years? Yes / No

Physician's Name _____ Phone Number ( )_____

Please list any medications currently being taken _____

Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Local anesthetic (Novocaine or Xylocaine)	Yes / No Erythromycin
Yes / No Codeine	Yes / No Demerol	Yes / No Tetracycline
Yes / No Latex	Yes / No Penicillin	Yes / No Vicodin
Yes / No Valium	Yes / No Sulfa Drugs	Other Drugs _____

Have you experienced any of the following? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation (within last 2 weeks)	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever (within last 2 weeks)	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Have you had or do you have any of the following? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No Hospitalization	Yes / No Asthma
Yes / No Family history of heart disease	Yes / No Diabetes	Yes / No Hepatitis
Yes / No Heart attack	Yes / No Family history of diabetes	Yes / No Sexual transmitted disease
Yes / No Artificial joint	Yes / No Tumors or cancer	Yes / No Herpes
Yes / No Stomach problems or ulcers	Yes / No Chemotherapy	Yes / No Canker or cold sores
Yes / No Heart defects	Yes / No Radiation	Yes / No Anemia
Yes / No Heart murmurs	Yes / No Arthritis, rheumatism	Yes / No Liver disease
Yes / No Rheumatic fever	Yes / No Emphysema or other lung disease	Yes / No Eye disease
Yes / No Skin disease	Yes / No Kidney or bladder disease	Yes / No Transplants
Yes / No Hardening of arteries	Yes / No Stroke	Yes / No Tuberculosis
Yes / No High blood pressure	Yes / No Eating disorders	Yes / No AIDS/HIV
Yes / No Seizures	Yes / No Osteoporosis	Yes / No Anxiety or Depression

If you have or had any disease, condition or problem not listed please list here: _____

Are you taking or have you taken any of the following in the last three months? (Please circle Yes or No for each)
Yes / No Tobacco in any form Yes / No Bisphosphonate (Fosamax) Yes / No Fen-Phen Yes / No Recreational drugs Yes / No Alcohol

Women only (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____ Yes / No Are you nursing? Yes / No Are you taking birth control pills?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.
I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient
Parent or Guardian _____ Date_____

Signature of Dentist _____ Date _____