

Medical History

Are you wearing Contact Lenses? Yes No If yes Do you use Tobacco? Yes No If yes Do you use controlled substances? If yes, please explain: Yes No If yes Women: Are you Pregnant or Trying to get pregnant? Taking oral contraceptives? Nursing? Are you allergic to any of the following? Aspirin Penicilin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs	Patient Name:		Birth Date:		Da	te Created:
Ace you taking any medications pills, or drugs? Please list drugs: Ves No If yes Los you use alachend? Ves No If yes Ace you ware Tobacco? Ves No If yes Do you use Tobacco? If yes, please explain: Ves No If yes Moment: Are you Pregnant or Trying to get pregnant? Taking oral contacceptives? Nursing? Acytic Acytic Acytic Acytic Periodin Periodin Periodin Periodin Periodin Periodin Periodin Periodin Post No If yes Do you have, or have you had, any of the following? Acid Anaphylania Ves No Lung Disease Ves No Achima Ves No Casterpoolss Ves No Achima Ves No Casterpoolss Ves No Achima Ves No Casterpoolss Ves No Casterpools Ves No Casterpoolss Ves No	Are you under Medical Treatment now? If yes, p	lease explain:	Yes	No 💮	If yes	
De you use alcohal? Yes No If yes Are you warring contract Lenser? Yes No If yes Do you use controlled substances? If yes, please explain: Yes No If yes Do you use controlled substances? If yes, please explain: Yes No If yes Wemen: Are you Pregnant or Trying to get pregnant? Taking oral contraceptives? Nursing? Are you alterajc to any of the following? Are you alterajc to any of the following? Are you have, or have you had, any of the following? Alos / Int Positive Yes No Do you have, or have you had, any of the following? Do you have, or have you had, any of the following? Do you have, or have you had, any of the following? Alos / Int Positive Yes No Costeoporols Arificial Heart Valve Yes No Descriptive Yes No Descriptive Yes No Descriptive Yes No Descriptive Arithman Yes No Descriptive Yes N	Have you ever been hospitalized? If yes, please	Yes	No 💮	If yes		
Are you wearing Contact Lenses? Yes No If yes Do you use Controlled substances? If yes, please explain: Pegnant or Trying to get pregnant? Taking oral contraceptives? Nursing? Are you allergic to any of the following? Are you allergi	Are you taking any medications, pills, or drugs?	Yes	No 🔵	If yes		
Do you use Totacco?	Do you use alcohol?	Yes	No 💮	If yes		
Do you use controlled substances? If yes, please explain: Pergnant of Trying to get pregnant? Taking oral contraceptives? Nursing?	Are you wearing Contact Lenses?		Yes	No 💮	If yes	
Women: Are you Pregnant or Trying to get pregnant? Are you allergic to any of the following? Applin Applin Penicilin Codeine Local Anesthetics Sulfa Drugs Cither? If yes, please explain: Do you have, or have you had, any of the following? ADS / HTV Positive Yes No Liver Disease Yes No Lung Disease Yes No Artificial Heart Valve Yes No Roules Easity Yes No Roule	Do you use Tobacco?		Yes	No 💮	If yes	
Pregnant or Trying to get pregnant? Taking oral contraceptives? Nursing? Are you allergic to any of the following? Applied Penicilin Codeine Local Anesthetics Actylic Metal Latex Sulfa Drugs Other? If yes, please explain: Ves No If yes Do you have, or have you had, any of the following? AlDS / HIV Positive Yes No Lung Disease Yes No Anaphylaxis Yes No Datespropriate Yes No Anaphylaxis Yes No Datespropriate Yes No Parathyroid Disease Yes No Antificial Heart Valve Yes No Parathyroid Disease Yes No Renal Dialysis Yes No Renal Dialysis Yes No Chemotherapy Yes No Shingles Yes No Concusions Yes No Stomach / Intestinal Disease Yes No Concusions Yes No Totalitis Yes No Concusions Yes No Totalitis Yes No Concusions Yes No Anaphylaxis Yes No Concusions Yes No Anaphylaxis Yes No Concusions Yes No Stomach / Intestinal Disease Yes No Concusions Yes No Totalitis Yes	Do you use controlled substances? If yes, please	e explain:	Yes	No 💮	If yes	
Are you allergic to any of the following? Appirin Penicilin Acrylic Metal Codeine Latex Sulfa Drugs Other? If yes, please explain: Ves No If yes Do you have, or have you had, any of the following? AlDS / HIV Positive Araphylaxis Yes No Liver Disease Yes No Artificial Heart Valve Yes No Artificial Heart Valve Yes No Readiation Therapy Yes No Readiation	Women: Are you					
Aspirin Penicilin Codeine Local Anesthetics Sulfa Drugs Other? if yes, please explain: Ves No If yes Do you have, or have you had, any of the following?	Pregnant or Trying to get pregnant?	Taking oral	contraceptives?		Nursing?	
Acrylic Metal Latex Sulfa Drugs Other? If yes, please explain: Ves No If yes Do you have, or have you had, any of the following? AIDS / HIV Positive Yes No Liver Disease Yes No Anaphylaxis Yes No Osteoporosis Yes No Anaphylaxis Yes No Datoporosis Yes No Asthma Yes No Bealthy Parathyroid Disease Yes No Asthma Yes No Renal Dialysis Yes No Bealthy Yes No Shingles Yes No Convulsions Yes No Stomach / Intestinal Disease Yes No Bealthy Winded Yes No Tonsillits Yes No Epilepsy or Seizures Yes No Tonsillits Yes No Recease Yes No Decease Yes No Decease Yes No Decease Yes No Decease Yes No Tonsillits Yes No Tonsillits Yes No Decease Ye	Are you allergic to any of the following?					
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Do you have, or have you had, any of the following? AIDS / HIV Positive Yes No Liver Disease Yes No Anaphylaxis Yes No Lung Disease Yes No Antificial Heart Valve Yes No Parathyroid Disease Yes No Artificial Heart Valve Yes No Radiation Therapy Yes No Renal Diabysis Yes No Renal Diabysis Yes No Renal Diabysis Yes No Renal Diabysis Yes No Corvulsions Yes No Shinus Trouble Yes No Salaly Winded Yes No Tonsillitis	Acrylic	Metal			Latex	Sulfa Drugs
AIDS / HIV Positive Yes No Liver Disease Yes No Anaphylaxis Yes No Lung Disease Yes No Anaphylaxis Yes No Lung Disease Yes No Anaphylaxis Yes No Osteoporosis Yes No Anaphylaxis Yes No Osteoporosis Yes No Artificial Heart Valve Yes No Parathyroid Disease Yes No Asthma Yes No Radiation Therapy Yes No Blood Transfusion Yes No Radiation Therapy Yes No Bruise Easity Yes No Renal Dialysis Yes No Chemotherapy Yes No Shingles Yes No Chemotherapy Yes No Shingles Yes No Cold Sores / Fever Blisters Yes No Shingles Yes No Convulsions Yes No Stomach / Intestinal Disease Yes No Diabetes Yes No Stomach / Intestinal Disease Yes No Easily Winded Yes No Tonsillitis Yes No Frequent Cough Yes No Alzheimer's Disease Yes No Genital Herpes Yes No Arthritis / Gout Yes No Heart Murmur Yes No Arthritis / Gout Yes No Heart Trouble / Disease Yes No Breathing Problems Yes No Heart Murmur Yes No Breathing Problems Yes No Herpes Yes No Cancer Yes No Cancer Yes No Herpes Yes No Cancer	Other? If yes, please explain:	Yes	No O		If yes	
Anaphylaxis Yes No Cateoporosis Yes No Angina Yes No Osteoporosis Yes No Angina Yes No Osteoporosis Yes No Angina Yes No Osteoporosis Yes No Antificial Heart Valve Yes No Parathyroid Disease Yes No Asthma Yes No Radiation Therapy Yes No Renal Dialysis Yes No Blood Transfusion Yes No Renal Dialysis Yes No Chemotherapy Yes No Shingsey Yes No Chemotherapy Yes No Shingsey Yes No Cold Sores / Fever Bilsters Yes No Shingsey Yes No Cold Sores / Fever Bilsters Yes No Shingsey Yes No Convulsions Yes No Stomach / Intestinal Disease Yes No Diabetes Yes No Swelling of Limbs Yes No Easily Winded Yes No Tonsillitis Yes No Excessive Thirst Yes No Alzheimer's Disease Yes No Alzheimer's Disease Yes No Anemia Yes No Anemia Yes No Heart Murmur Yes No Artificial Joint Yes No Heart Murmur Yes No Breathing Problems Yes No Heart Trouble / Disease Yes No Breathing Problems Yes No Henophilia Yes No Breathing Problems Yes No Henophilia Yes No Cancer Yes No Help Cholesterol Yes No Chest Pains Y	Do you have, or have you had, any of the follow	wing?			Do you have, or have you had	I, any of the following?
Angina Yes No Osteoporosis Yes No Artificial Heart Valve Yes No Parathyroid Disease Yes No Asthma Yes No Radiation Therapy Yes No Blood Transfusion Yes No Renal Dialysis Yes No Bruise Easity Yes No Renal Dialysis Yes No Chemotherapy Yes No Shingles Yes No Chemotherapy Yes No Shingles Yes No Corvousions Yes No Sinus Trouble Yes No Sinus Trouble Yes No Diabetes Yes No Stomach / Intestinal Disease Yes No Easity Winded Yes No Tonsillitis Yes No Excessive Thirst Yes No Tumors / Growth Yes No Excessive Thirst Yes No Alzheimer's Disease Yes No Genital Herpes Yes No Arthritis / Gout Yes No Heart Murmur Yes No Blood Disease Yes No Hemphilia Yes No Bereathing Problems Yes No Herpes Yes No Cancer Yes No Herpes Yes No Cancer Yes No Herpes No Cancer Yes No Herpes No Cancer Yes No Herpes No Cancer Yes No Cancer Yes No Herpes No Cancer Yes No Ca	AIDS / HIV Positive	Yes	No No		Liver Disease	Yes No
Artificial Heart Valve Asthma Yes No Radiation Therapy Yes No Renal Dialysis Yes No Shingles Yes No Shingles Yes No Shingles Yes No Sinus Trouble Yes No Stomach / Intestinal Disease Yes No Swelling of Limbs Yes No Tonsillitis Yes No Tonsillitis Yes No Tumors / Growth Yes No Alzheimer's Disease Yes No Anemia Yes No Arthritis / Gout Yes No Arthritis / Gout Yes No Heart Murmur Yes No Breathing Problems Yes No Breathing Problems Yes No Hopplycemia Yes No Congenital Heart Disorder	Anaphylaxis	Yes	No No		Lung Disease	Yes No
Ashtma Yes No Radiation Therapy Yes No Renal Dialysis Blood Transfusion Yes No Renal Dialysis Yes No Shingles Yes No Shingles Yes No Sinus Trouble Yes No Sinus Trouble Yes No Stomach / Intestinal Disease Yes No Swelling of Limbs Yes No Swelling of Limbs Yes No Tonsillitis Yes No Tonsillitis Yes No Tumors / Growth Yes No Wenereal Disease Yes No Alzheimer's Disease Yes No Alzheimer's Disease Yes No Hay Fever Yes No Arthritis / Gout Yes No Arthritis / Gout Yes No Heart Murmur Yes No Blood Disease Yes No Breathing Problems Yes No Hay Fever Yes No Breathing Problems Yes No Hay Cancer Yes No Cancer Yes No Chest Pains Yes No Chest Pains Yes No Chest Pains Yes No Congenital Heart Disorder Yes No Chest Pains Yes No Congenital Heart Disorder	Angina	Yes	No No		Osteoporosis	Yes No
Blood Transfusion Yes No Renal Dialysis Yes No Shingles Yes No Shingles Yes No Shingles Yes No Sinus Trouble Yes No Stomach / Intestinal Disease Yes No Swelling of Limbs Yes No Renal Dialysis Yes No Alzheimer's Disease Yes No Alzheimer's Disease Yes No Anemia Yes No Arthritis / Gout Yes No Heart Murmur Yes No Arthritis / Gout Yes No Heart Murmur Yes No Blood Disease Yes No Breathing Problems Yes No Herpes Yes No Cancer Yes No Herpes Yes No Cancer Yes No Chest Pains Yes No Chest Pains	Artificial Heart Valve	Yes	No No		Parathyroid Disease	Yes No
Bruise Easity Yes No Rheumatism Yes No Chemotherapy Yes No Shingles Yes No Shingles Yes No Chemotherapy Yes No Shingles Yes No Sinus Trouble Yes No Corovulsions Yes No Stomach / Intestinal Disease Yes No Diabetes Yes No Swelling of Limbs Yes No Easily Winded Yes No Tonsillitis Yes No Excessive Thirst Yes No Venereal Disease Yes No Frequent Cough Yes No Alzheimer's Disease Yes No Genital Herpes Yes No Arthritis / Cout Yes No Heart Murmur Yes No Arthritis / Cout Yes No Heart Trouble / Disease Yes No Hemophilia Yes No Breathing Problems Yes No Herpes Yes No Cancer Yes No Herpes Yes No Cancer Yes No Herpes Yes No Cancer Yes No Heppelycemia Yes No Chest Pains Yes No Chest Pa	Asthma	Yes	No No		Radiation Therapy	Yes No
Chemotherapy Yes No Shingles Yes No Sinus Trouble Yes No Sinus Trouble Yes No Sinus Trouble Yes No Stomach / Intestinal Disease Yes No Swelling of Limbs Yes No Marchielitis Yes No Marchielitis / Gout Yes No Ma	Blood Transfusion	Yes	No No		Renal Dialysis	Yes No
Cold Sores / Fever Blisters Yes No Sinus Trouble Yes No Diabetes Yes No Stomach / Intestinal Disease Yes No Diabetes Yes No Swelling of Limbs Yes No Tonsillitis	Bruise Easity	Yes	No No		Rheumatism	Yes No
Convulsions Yes No Stomach / Intestinal Disease Yes No Swelling of Limbs Yes No Swelling of L	Chemotherapy	Yes	No No		Shingles	Yes No
Diabetes Yes No Swelling of Limbs Yes No Easily Winded Yes No Tonsillitis Yes No Tonsillitis Yes No Easily Winded Yes No Tonsillitis Yes No Tonsillitis Yes No Epilepsy or Seizures Yes No Tumors / Growth Yes No Excessive Thirst Yes No Venereal Disease Yes No Alzheimer's Disease Yes No Genital Herpes Yes No Anemia Yes No Arthritis / Gout Yes No Heart Murmur Yes No Arthritis / Gout Yes No Heart Trouble / Disease Yes No Blood Disease Yes No Hempohilia Yes No Breathing Problems Yes No Heigh Cholesterol Yes No Cancer Yes No Helph Cholesterol Yes No Congenital Heart Disorder Yes No Helph Cholesterol Yes No Congenital Heart Disorder Yes No Congenital Heart Disorder Yes No Congenital Heart Disorder Yes No No Congenital Heart Disorder Yes No No Congenital Heart Disorder Yes No Congenital Heart Disorder Yes No No Congenital Heart Disorder Yes No Congenital	Cold Sores / Fever Blisters	Yes	No 💮		Sinus Trouble	Yes No
Easily Winded Yes No Tonsillitis Yes No Epilepsy or Seizures Yes No Tumors / Growth Yes No Excessive Thirst Yes No Venereal Disease Yes No Alzheimer's Disease Yes No Genital Herpes Yes No Anemia Yes No Arthritis / Gout Yes No Heart Murmur Yes No Arthritis / Gout Yes No Heart Trouble / Disease Yes No Blood Disease Yes No Hempohilia Yes No Breathing Problems Yes No Heigh Cholesterol Yes No Cancer Yes No Helph Cholesterol Yes No Congenital Heart Disorder Yes No	Convulsions	Yes	No No		Stomach / Intestinal Disease	Yes No
Epilepsy or Seizures Yes No Tumors / Growth Yes No Venereal Disease Yes No Alzheimer's Disease Yes No Anemia Yes No Anemia Hay Fever Heart Murmur Yes No Artificial Joint Yes No Breathing Problems Yes No Breathing Problems Yes No Cancer Yes No Cancer Yes No Congenital Heart Disorder Yes No Congenital Heart Disorder	Diabetes	Yes	No No		Swelling of Limbs	Yes No
Excessive Thirst Yes No Venereal Disease Yes No Alzheimer's Disease Yes No Anemia Anemia Yes No Anemia Yes No Arthritis / Gout Hay Fever Heart Murmur Yes No Artificial Joint Yes No Blood Disease Yes No Breathing Problems Yes No Hemophilia Herpes Yes No Cancer Yes No Chest Pains Yes No Congenital Heart Disorder Yes No Congenital Heart Disorder	Easily Winded	Yes	No No		Tonsillitis	Yes No
Frequent Cough Yes No Alzheimer's Disease Yes No Anemia Anemia Yes No Anemia Yes No Anemia Yes No Arthritis / Gout Heart Murmur Heart Trouble / Disease Yes No Blood Disease Yes No Breathing Problems Yes No Herpes Herpes Herpes Herpes Yes No Cancer Yes No Chest Pains Yes No No Congenital Heart Disorder Yes No No Congenital Heart Disorder	Epilepsy or Seizures	Yes	No No		Tumors / Growth	Yes No
Genital Herpes Yes No Anemia Yes No Anemia Yes No Arthritis / Gout Yes No Blood Disease Yes No Blood Disease Yes No Breathing Problems Yes No Herpes Yes No Cancer Yes No Herpes No Cancer Yes No Heppes No Chest Pains Yes No Heppoglycemia Yes No Congenital Heart Disorder Yes No No Congenital Heart Disorder Yes No No Congenital Heart Disorder	Excessive Thirst	Yes	No No		Venereal Disease	Yes No
Hay Fever Yes No Arthritis / Gout Yes No Arthritis / Gout Yes No Heart Murmur Yes No Artificial Joint Yes No Heart Trouble / Disease Yes No Blood Disease Yes No Breathing Problems Yes No Herpes Yes No Cancer Yes No Heppes No Cancer Yes No Heppes No Cancer Yes No Chest Pains Yes No Heppes No Congenital Heart Disorder Yes No Congenital Heart Disorder Yes No No Congenital Heart Disorder	Frequent Cough	Yes	No No		Alzheimer's Disease	Yes No
Heart Murmur Yes No Artificial Joint Yes No Heart Murmur Heart Trouble / Disease Yes No Blood Disease Yes No Breathing Problems Yes No Cancer Yes No Chest Pains Yes No Hypoglycemia Yes No Congenital Heart Disorder Yes No No Congenital Heart Disorder	Genital Herpes	Yes	No No		Anemia	Yes No
Heart Trouble / Disease Yes No Blood Disease Yes No Hemophilia Yes No Breathing Problems Yes No Herpes Yes No Cancer Yes No High Cholesterol Yes No Chest Pains Yes No Hypoglycemia Yes No Congenital Heart Disorder Yes No No Congenital Heart Disorder	Hay Fever	Yes	No No		Arthritis / Gout	Yes No
Hemophilia Yes No Breathing Problems Yes No Herpes No Cancer Yes No High Cholesterol Yes No Chest Pains Yes No Hypoglycemia Yes No Congenital Heart Disorder Yes No No Hypoglycemia	Heart Murmur	Yes	No No		Artificial Joint	Yes No
Herpes Yes No Cancer Yes No High Cholesterol Yes No Chest Pains Yes No Hypoglycemia Yes No Congenital Heart Disorder Yes No No Congenital Heart Disorder	Heart Trouble / Disease	Yes	No No		Blood Disease	Yes No
High Cholesterol Yes No Chest Pains Yes No Hypoglycemia Yes No Congenital Heart Disorder Yes No No Congenital Heart Disorder	Hemophilia	Yes	No 💮		Breathing Problems	Yes No
Hypoglycemia Yes No Congenital Heart Disorder Yes No	Herpes	Yes	No 💮		Cancer	Yes No
	High Cholesterol	Yes	No 💮		Chest Pains	Yes No
Kidney Problems Yes No Cortisone Medicine Yes No No	Hypoglycemia	Yes	No 💮		Congenital Heart Disorder	Yes No
	Kidney Problems	Yes	No No	I	Cortisone Medicine	Yes No



Medical History

Do you have, or have you had, any of the following?						Do you have, or have you had, any of the following?				
Drug Addiction	Yes		No			Low Blood Pressure	Yes		No 💮	
Emphysema	Yes		No			Mitral Valve Prolapse	Yes		No 🔵	
Excessive Bleeding	Yes		No			Pain in Jaw Joints	Yes		No 💮	
Fainting Spells / Dizziness	Yes		No			Psychiatric Care	Yes		No 💮	
Frequent Diarrhea	Yes		No			Recent Weight Loss	Yes		No 💮	
Glaucoma	Yes		No			Rheumatic Fever	Yes		No 💮	
Heart Attack / Failure	Yes		No			Scarlet Fever	Yes		No 💮	
Heart Pacemaker	Yes		No			Sickle Cell Disease	Yes		No 🔵	
Hepatitis A	Yes		No			Spina Bifida	Yes		No 🔵	
Hepatitis B or C	Yes		No			Stroke	Yes		No 🔵	
High Blood Pressure	Yes		No			Thyroid Disease	Yes		No 🔵	
Hives or Rash	Yes		No			Tuberculosis	Yes		No 🔵	
Irregular Heartbeat	Yes		No			Ulcers	Yes		No 💮	
Leukemia	Yes		No							
Dental History					I	Dental History				
Do your gums bleed while brushing or flossing?	Yes		No			Are your teeth sensitive to hot or cold?	Yes		No 💮	
Are your teeth sensitive to sweet or sour items?	Yes		No			Do you feel pain to any of your teeth?	Yes		No No	
Do you have sores or lumps in or near your mouth?	Yes		No			History of Periodontal Therapy?	Yes		No 💮	
Do you snore or have been told you snore?	Yes		No			Have you ever received oral hygiene instructions?	Yes		No	
Have you had any head, neck or jaw injury?	Yes		No			Do you bite your lips or cheeks frequently?	Yes		No	
Have you ever had any difficulties with extracting a tooth?	Yes		No			Have you had orthodontic treatment?	Yes		No 💮	
Have you ever experienced prolonged bleeding?	Yes		No			Do you wear partials or dentures?	Yes		No 💮	
Do you have frequent headaches?	Yes		No			Do you clench or grind your teeth?	Yes		No 💮	
Have you experienced pain in any of the following areas:						Do you have clicking or popping in your jaw?	Yes		No 💮	
Face Mouth Ears Joints						Do you have difficulty in opening or closing your jaw?	Yes		No 💮	
Difficulty in chewing?	Yes		No			Is there anything you would like to change about your			No 💮	
3						smile?				
If yes, what?						If yes, what?				
To the best of my knowledge the questions on this form h	ave be	en acc	curate	ely answe	red. I unders	stand that providing incorrect information can be dang	gerou	s to my	,	
(or patient's) health. It is my responsibility to inform the d	ental c	office o	f any	changes	in medical s	status.				
Signature of Patient, Parent or Guardian:										
x						Data				
					_	Date				