

Your Name: _____ Today's date: _____

Physician's Name: _____ Phone # _____

When was your last visit to your physician? _____ When was your last complete physical? _____

MEDICAL HISTORY

Please tell us if you have had any of the following by checking the appropriate box:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bacterial Endocarditis | <input type="checkbox"/> Anemia/ Blood Problems | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> Rheumatic Heart Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Cancers, Tumors, Growths |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Eye Disorders/ Glaucoma | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Heart Attack _____ year | <input type="checkbox"/> AIDS | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Immunosuppressive Disorders | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Any Artificial Replacement- Knee, Hip, Joint, Pins, Plate | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rheumatism/ Arthritis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Hemophelia | <input type="checkbox"/> Epilepsy/ Seizures | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Sickle Cell Anemia | | <input type="checkbox"/> Fever Blisters |
| | | <input type="checkbox"/> Pregnant _____ weeks |
| | | <input type="checkbox"/> Oral Contraceptives |

Please list and **ALLERGIES** to Drugs, Medications, of Anesthetics _____

Please list any other **MEDICAL CONDITIONS** not mentioned above _____

Please list all **DRUGS/ MEDICATIONS** that you currently take (include the dosage and frequency) _____

Have you ever had **BOTOX** or **DERMAL FILLERS**? If yes, when was last treatment? _____

Are you interested in receiving information regarding **BOTOX** and **DERMAL FILLERS**? _____

DENTAL HISTORY

Please describe your chief oral complaint _____

- | | | | |
|--|-----|--|-----|
| Are your teeth sensitive to: | | Do you like the appearance of your smile? | Y N |
| Heat? | Y N | Can you chew comfortably on both sides | |
| Cold? | Y N | of your mouth? | Y N |
| Sweets? | Y N | If you could improve your teeth or smile, what would you do? _____ | |
| Chewing? | Y N | Do you consider yourself a nervous patient? | Y N |
| Do your gums ever feel tender or swollen? | Y N | Have you ever had an unpleasant dental experience? | Y N |
| Do your gums bleed when brushing? | Y N | When was your last dental appointment? _____ | |
| Have you ever been treated for periodontal disease? | Y N | When were your last dental xrays? _____ | |
| Do you use dental floss? | Y N | What was done at that visit? _____ | |
| Have you had any previous injuries to your face or jaws? | Y N | _____ | |
| Do you clench or grind your teeth? | Y N | Where was it done? _____ | |
| When was your last cleaning? _____ | | Have you ever experienced problems with novocaine? | Y N |
| Have you had your teeth cleaned regularly? | Y N | Are you interested in receiving information on tooth whitening? | Y N |
| Would you like to keep your natural teeth? | Y N | | |