

## MEDICAL INFORMATION

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Are you presently under medical treatment? Y N \_\_\_\_\_  
 Have you ever had any major operations? Y N \_\_\_\_\_  
 Have you ever had any head / neck injuries? Y N \_\_\_\_\_  
 Are you presently taking any medications? Y N Please List \_\_\_\_\_  
 \_\_\_\_\_

Women: Pregnant or trying Y N Nursing Y N Taking Contraceptives Y N

Are allergic or have you had an adverse reaction to any substance or drug? Y N  
 Aspirin Penicillin Codeine Sulfa Drugs Latex Rubber Acrylic Metal  
 Other \_\_\_\_\_

Do you have now or have you ever been told you have any of the following:

Heart Murmur	Y	N	_____
Congenital Heart Disorder	Y	N	_____
Artificial Heart Valve(s)	Y	N	_____
Any Other Heart Ailment	Y	N	_____
Any Blood Disease	Y	N	_____
Hypertension	Y	N	_____
Stroke	Y	N	_____
Hepatitis	Y	N	_____
Other Liver Disease	Y	N	_____
Kidney Disease	Y	N	_____
Diabetes	Y	N	_____
Artificial Joint(s)	Y	N	_____
HIV or AIDS	Y	N	_____
Other Medical Problems			_____

## DENTAL INFORMATION

Do you have a specific dental problem?	Y	N
In the past, have you had dental examinations on a routine basis?	Y	N
Do you have pain in or near your ears?	Y	N
Do you have now or have you ever had sores in or around your mouth?	Y	N
Do your gums bleed when brushing and or flossing?	Y	N
Do you think you have active dental decay or gum disease?	Y	N
Does any part of your mouth hurt when you bite?	Y	N
Do you think you grind or clench your teeth?	Y	N
Is there anything about your smile that you would like to change?	Y	N
Are there any dental procedures you are interested in?	Y	N

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*To the best of my knowledge, all the preceding answers are correct. If any health status and/or any change of medicines occur I will inform this office.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Reviewed By \_\_\_\_\_ Date \_\_\_\_\_