NAME:____

WHAT IS YOUR IMMEDIATE CONCERN: ____

WHEN WAS YOUR LAST DENTAL EXAM: ____

Medical History

Please check all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma, Emphysema, COPD
- ☐ Back Problems
- ☐ Blood Disorder
- ☐ Cancer; Type_____________
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cold Sores/Canker Sores
- ☐ Congenital Heart Lesions, Artificial Heart Valve
- ☐ Diabetes
- ☐ Digestive Disorder/Reflux
- ☐ Eating Disorder
- ☐ Epilepsy/Convulsions
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Hepatitis; Type_____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ STD; Type_______________
- ☐ Stroke/Blood Clots
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors/Abnormal Growths
- ☐ Other___________________

Are you pregnant? Yes No Are you nursing? Yes No

Allergies:

- ☐ Aspirin/Ibuprofen
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Other______________

Medications: Please list any medications you are currently taking and the condition in which you taking it for:

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Dental History

Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Cigarette/pipe/cigar smoking
- ☐ Clicking or popping jaw/Jaw pain
- ☐ Dry mouth
- ☐ Food collection between teeth
- ☐ Grinding or Clenching teeth/Use bite appliance
- ☐ Loose teeth/broken fillings
- ☐ Mouth breathing
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Sensitivity to heat, cold, sweets