Medical History

Patient Name: _____ D/O/B: _____

Do you have a Primary Care Physician? If yes, who? Y☐ N☐: _____
Have you ever been hospitalized or had a major operation? Y☐ N☐: _____
Have you ever had a serious head or neck injury? Y☐ N☐: _____
Have you ever taken any medication containing bisphosphonates? Y☐ N☐: _____
Do you use tobacco? Y☐ N☐ Do you use controlled substances? Y☐ N☐ _____
Do you have any serious illnesses not listed above? Y☐ N☐: _____

Please list all medications you are currently taking (or provide a copy of your list for us): _____
_____

Preferred Pharmacy: _____ City: _____
Emergency Contact: _____ Phone Number: _____ Relationship: _____

Are you allergic to any of the following?
Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐
Sulfa Drugs ☐ Local Anesthetics ☐ Other ☐ _____

Do you have, or have you had, any of the following. Please check mark to confirm:

☐ Acid Reflux	☐ Cortisone Medicine	☐ Hepatitis A	☐ Recent Weight Loss
☐ AIDS/HIV	☐ Dementia	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anaphylaxis	☐ Diabetes	☐ Herpes	☐ Rheumatic Fever
☐ Anemia	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis	☐ Dry mouth	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Easily winded	☐ Hives/Rash	☐ Shingles
☐ Artificial Joint(s)	☐ Emphysema	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Epilepsy or Seizures	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Excessive Bleeding	☐ Kidney Problems	☐ Sleep Apnea
☐ Breathing problems	☐ Fainting	☐ Liver Disease	☐ Stomach/Intestinal Disease
☐ Bruise Easily	☐ Frequent cough	☐ Low Blood Pressure	
☐ Bypass surgery	☐ Frequent headaches	☐ Lung Disease	☐ Stroke
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Swelling of Limbs
☐ Canker sores	☐ Hay Fever	☐ Organ Transplant	☐ Thyroid Disease
☐ Chest pain	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tonsillitis
☐ Cold Sores	☐ Heart Murmur	☐ Parathyroid Disease	☐ Tuberculosis
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Pain in jaw joints	☐ Tumors or Growths
	☐ Heart Trouble/Disease	☐ Psychiatric care	☐ Ulcers
☐ Convulsions	☐ Hemophilia	☐ Radiation Treatment	

Women:
Pregnant☐ Trying to get Pregnant☐ Nursing☐ Taking Oral Contraceptives☐

Are you interested in a brighter smile? Y☐ N☐ Are you interested in a straighter smile? Y☐ N☐
Do you have jaw pain? Y☐ N☐ Do you have a history of periodontal disease? Y☐ N☐
Do you have a denture and/or partial? Y☐ N☐ Do you have a dental implant? Y☐ N☐
Does dental treatment make you anxious? Y☐ N☐ if yes, please explain: _____

Patient signature: _____ Date: _____