Medical History

Have you been diagnosed with or are you currently under treatment for any of the following?

YES	NO	Heart Disease	YES	NO	Thyroid Disease	YES	NO	Cancer
YES	NO	Irregular Heartbeat	YES	NO	Respiratory Disease	YES	NO	Tumors or Growths
YES	NO	Angina	YES	NO	Asthma	YES	NO	Radiation Treatment
YES	NO	Artificial Heart Valve	YES	NO	Sinus Trouble	YES	NO	Seizure Disorder
YES	NO	Pacemaker	YES	NO	Allergies	YES	NO	Immune Disorder
YES	NO	Stroke	YES	NO	Tuberculosis	YES	NO	AIDS/HIV
YES	NO	Organ Transplant	YES	NO	Diabetes	YES	NO	Shingles
YES	NO	High Blood Pressure	YES	NO	Hypoglycemia	YES	NO	STD
YES	NO	Liver Disease	YES	NO	Anemia	YES	NO	Cold Sores/Fever Blister
YES	NO	Hepatitis	YES	NO	Bleeding Disorder	YES	NO	Sleep Apnea
YES	NO	Kidney Disease	YES	NO	Osteoporosis	YES	NO	Mental Illness
YES	NO	Stomach Disease	YES	NO	Artificial Joint	YES	NO	Chemical Dependency
YES	NO	Intestinal Disease	YES	NO	Arthritis	YES	NO	Alcoholism

Other_________________________

Are you allergic to any of the following? If yes, please circle Aspirin Penicillin Acrylic Metal Latex

Are you taking any medications ? YES NO If yes, please list_____________________________________

Are you under a physician's care now? YES NO If yes, name________________________________

Women: Are you

YES NO Pregnant? YES NO Nursing? YES NO Taking oral contraceptives?

Dental History

Reason For today's visit____

Date of last dental visit_________________________ Were x-rays taken? YES NO

When was your last Panoramic (Full Mouth) x-ray taken?___________________________________

Do you have or have you ever had any of the following?

YES	NO	Jaw Joint Pain	YES	NO	Temperature Sensitivity
YES	NO	Grinding or Clenching of teeth	YES	NO	Orthodontics (Braces)
YES	NO	Dry Mouth	YES	NO	Periodontal Disease (gum disease)
YES	NO	Are you happy with your smile?			

If not, why?____

Signature of patient, parent, or guardian__________________________________Date________________