Medical History

NAME:_____Birthdate:_____

Mother (If Minor)_____Father (If Minor)_____

Physician's Name:_____Number:_____
Cardiologist's Name: _____ Number:_____
Emergency Contact Name: _____Number:_____

Please indicate with a check mark – if you have, or have had, any of the following:

_____Heart Problems
_____Mitral Valve Prolapse*
_____Heart Murmur*
_____Pacemaker*
_____Defibrillator*, Active Implanted Medical Device*
_____Prosthetic Cardiac Valve*
_____History of Bacterial Endocarditis*
_____Congenital Heart Disease*
_____Rheumatic Fever*
_____Stroke
_____Angina
_____Congestive Heart Failure
_____Heart Attack*
_____Heart Surgery*
_____Pulmonary Shunts/Conduits*
_____Stents*
_____Artificial Heart Valves*
_____A Cardiac Transplant*
_____High Cholesterol
_____High Blood Pressure
_____Circulatory Problems
_____Excessive Bleeding
_____Anemia
_____Hepatitis
Type _____
Status _____
_____Smoker
_____Cancer-Type_____
_____Family History Mouth/Throat Cancer
_____Radiation Treatments
_____Chemo/IV Bisphosphonate
_____Kidney Problems
_____Liver Problems
_____Blood Transfusion, If Yes, When _____
_____Current Invitro Treatment*

_____Diabetes: 1 / 2/Gestational/Family History
_____Endocrine Disease, i.e. Thyroid
_____Prosthetic replacements, i.e. Joints*
_____Pins*, Screws*, Plates*
_____Venereal Disease
_____Cold Sores
_____Substance Abuse
_____Psychiatric Care
_____HIV/AIDS
_____Tuberculosis
Status _____
_____Asthma
_____History of Pneumonia
_____Sinus Problems
_____Eating Disorder
_____Previous use of Fen-Phen; Redux/Dexfenfluramine, Pondimin or Fenflurameine*
_____Arthritis: Osteoarthritis/Rheumatoid Arthritis
_____Osteoporosis
_____Oral Bisphosphonate Treatment
_____Paget's Disease
_____Epilepsy/Convulsions
_____Gastrointestinal Disease
_____Eye Disease i.e. Glaucoma
_____Hearing Impaired
_____Allergies to Novocaine
_____Allergies to Latex*
_____Allergies to medicines or drugs
_____Allergies to _____
_____Spina Bifida *
_____Pregnant (Currently)
_____Menopause
_____Birth Control Pills
_____Other - Explain _____

_____History of Oral Surgery/Orthodontics/Gum-Periodontal Surgery/Hospitalizations/Surgeries
Circle & Explain the above _____
Do You Have City Water _____ Well Water _____ Fluoride in Your Water _____

Reported Symptoms of:
_____Bleeding Gums
_____Dry Mouth
_____Burning Mouth
_____Unexplained Weight Gain
_____Unexplained Weight Loss
_____a lump or thickening in the mouth
_____ear pain
_____hoarseness
_____swelling which effects the fit of a denture
_____red, white or discolored lesions in the mouth or on the lips
_____ Problem or Complication with Previous Dental Treatment

____Excessive Hunger/Thirst/Frequent Urination
____Sour Taste especially in the morning
____Heart Burn
____Belching
____Frequent Canker Sores
____soreness/difficulty in chewing or swallowing
____difficulty moving the jaw or tongue
____numbness of the tongue or mouth
____repeated bleeding from the mouth or throat

If you answered YES to any of these (*) questions, please call the office before your appointment.

Please list all medications including over the counter medications, herbs or vitamins. Please list the name, dosage and use:

Name of Medication	**Dosage/Frequency**	**Use**

Please describe any current medical treatment, operations, or any other medical or dental information that may possibly affect your dental treatment. I understand that it is my responsibility to notify this office of any change in my medical history prior to treatment.

Signature:_____ Date: _____

UPDATES:

SMILE EVALUATION

Are you happy with your smile? Yes ___ No ___

Do you smile often? Yes ___ No ___

Do you try to hide your smile? Yes ___ No ___

Would you like your teeth to be whiter? Yes ___ No ___

Would you like your teeth to be straighter? Yes ___ No ___

Do you have spaces in between your teeth that you feel are unattractive? Yes ___ No __

Do you have old silver or black fillings that you consider unattractive? Yes ___ No ___

Do you have old crowns (caps) or tooth colored fillings that don't look quite as nice as they used to, or as nice as you would like? Yes ___ No ___

Do you show too much of your gums when you smile? Yes ___ No ___

When you smile, do your teeth show? Yes ___ No ___

Do you ever get compliments on your smile and/or teeth? Yes ___ No ___

If you had the ability to painlessly and quickly change anything about your smile, what would it be?

_____

_____

_____