

**MEDICAL AND HEALTH INFORMATION**

Personal Physician: \_\_\_\_\_

YES NO

- 1. Are you currently being treated by a physician? For what: \_\_\_\_\_
- 2. Are you currently taking any medications or drugs? For what: \_\_\_\_\_
- 3. Are you pregnant?
- 4. Are you taking birth control medication?
- 5. Do you smoke or use smokeless tobacco?
- 6. Do you take ASPIRIN or BLOOD THINNERS?

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:** (Please Circle)

- |                                 |  |              |
|---------------------------------|--|--------------|
| Aspirin                         | Sulpha Drugs   | Other: _____ |
| Iodine                          | Local Anesthetics  |              |
| Sedatives                       | Any Metals (gold, silver, mercury, silver, nickel, etc...) |              |
| Latex                           | Codeine or other narcotics                                 |              |
| Penicillin or other antibiotics |  |              |

**PLEASE CHECK IF BEING TREATED FOR OR HAVE BEEN TREATED FOR ANY OF THE FOLLOWING:**

- | YES                      | NO   | YES                      | NO   |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Any Heart Problems          | <input type="checkbox"/> | <input type="checkbox"/> Allergies to Anesthetics            |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Pressure              | <input type="checkbox"/> | <input type="checkbox"/> Allergies to Penicillin/antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> Artificial Joints           | <input type="checkbox"/> | <input type="checkbox"/> Anemia or other Blood Disorders     |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> | <input type="checkbox"/> Diabetes                            |
| <input type="checkbox"/> | <input type="checkbox"/> Circulatory Problems        | <input type="checkbox"/> | <input type="checkbox"/> Asthma                              |
| <input type="checkbox"/> | <input type="checkbox"/> Radiation Treatment         | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis A B C D E                 |
| <input type="checkbox"/> | <input type="checkbox"/> Excessive Bleeding          | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy / Seizures                 |
| <input type="checkbox"/> | <input type="checkbox"/> Excessive Bruising          | <input type="checkbox"/> | <input type="checkbox"/> Liver or Kidney Disease             |
| <input type="checkbox"/> | <input type="checkbox"/> Ulcers (stomach)            | <input type="checkbox"/> | <input type="checkbox"/> Tumor History                       |
| <input type="checkbox"/> | <input type="checkbox"/> Sinus Trouble               | <input type="checkbox"/> | <input type="checkbox"/> Stroke                              |
| <input type="checkbox"/> | <input type="checkbox"/> History of Bulimia/Anorexia | <input type="checkbox"/> | <input type="checkbox"/> Aids/ HIV                           |
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> | <input type="checkbox"/> Drug or Alcohol Dependency          |
| <input type="checkbox"/> | <input type="checkbox"/> Pacemaker/Defibulator       |                          |  |

**DENTAL INFORMATION:**

- | YES                      | NO   |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> 1. Do you have headaches, earaches or neck pains?   |
| <input type="checkbox"/> | <input type="checkbox"/> 2. Do you feel you grind or clench your teeth?  |
| <input type="checkbox"/> | <input type="checkbox"/> 3. Does your jaw "click" or hurt?   |
| <input type="checkbox"/> | <input type="checkbox"/> 4. Do your experience sensitivity with hot, cold or biting?   |
| <input type="checkbox"/> | <input type="checkbox"/> 5. Have you ever had your bite adjusted?  |
| <input type="checkbox"/> | <input type="checkbox"/> 6. Have you ever had orthodontic treatment?   |
| <input type="checkbox"/> | <input type="checkbox"/> 7. Do you snore or have you been told that you snore?   |
| <input type="checkbox"/> | <input type="checkbox"/> 8. Do you feel you may have bad breath at times?  |
| <input type="checkbox"/> | <input type="checkbox"/> 9. Do your gums bleed when you brush your teeth?  |
| <input type="checkbox"/> | <input type="checkbox"/> 10. Have you ever had periodontal (gum) treatment?  |
| <input type="checkbox"/> | <input type="checkbox"/> 11. Do you have or do your wear removable dental appliances?  |
| <input type="checkbox"/> | <input type="checkbox"/> 12. Have you ever had a serious/ difficult problem associated with previous Dental treatment? If so, explain: |

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE: \_\_\_\_\_ REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

UPDATE: \_\_\_\_\_

UPDATE: \_\_\_\_\_

UPDATE: \_\_\_\_\_