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	
☐	☐	Any Heart Problems	☐	☐	Allergies to Anesthetics
☐	☐	Blood Pressure	☐	☐	Allergies to Penicillin/antibiotics
☐	☐	Artificial Joints	☐	☐	Anemia or other Blood Disorders
☐	☐	Rheumatic Fever	☐	☐	Diabetes
☐	☐	Circulatory Problems	☐	☐	Asthma
☐	☐	Radiation Treatment	☐	☐	Hepatitis A B C D E
☐	☐	Excessive Bleeding	☐	☐	Epilepsy / Seizures
☐	☐	Excessive Bruising	☐	☐	Liver or Kidney Disease
☐	☐	Ulcers (stomach)	☐	☐	Tumor History
☐	☐	Sinus Trouble	☐	☐	Stroke
☐	☐	History of Bulimia/Anorexia	☐	☐	Aids/ HIV
☐	☐	Glaucoma	☐	☐	Drug or Alcohol Dependency
☐	☐	Pacemaker/Defibulator			

DENTAL INFORMATION:

YES NO

- ☐ ☐ **1. Do you have headaches, earaches or neck pains?**
- ☐ ☐ **2. Do you feel you grind or clench your teeth?**
- ☐ ☐ **3. Does your jaw "click" or hurt?**
- ☐ ☐ **4. Do your experience sensitivity with hot, cold or biting?**
- ☐ ☐ **5. Have you ever had your bite adjusted?**
- ☐ ☐ **6. Have you ever had orthodontic treatment?**
- ☐ ☐ **7. Do you snore or have you been told that you snore?**
- ☐ ☐ **8. Do you feel you may have bad breath at times?**
- ☐ ☐ **9. Do your gums bleed when you brush your teeth?**
- ☐ ☐ **10. Have you ever had periodontal (gum) treatment?**
- ☐ ☐ **11. Do you have or do your wear removable dental appliances?**
- ☐ ☐ **12. Have you ever had a serious/ difficult problem associated with previous Dental treatment? If so, explain:**

_____

SIGNATURE: _____ **REVIEWED BY:** _____**DATE:**_____

UPDATE: _____

UPDATE: _____

UPDATE: _____