	Medical History (c	ontinued)		· ·	Dental History		
Your cur	rent physical health is: Good	Fair Poor			Why have you come to the dentist today?		
Are you cu	urrently under the care of a physician?		Yes	No			
Please Exp	plain:	9					
Are you tal	king any prescription / over-the-counter of	drugs?	Yes	No			
Please list	each one:					es No	
Do you sm	noke or use tobacco in any other form?		Yes	No		es No	
For Wome	n: Are you taking birth control pills?		Yes	No	Have you ever had a serious / difficult problem associated with any previous dental work?	'es No	
Are you pre	egnant? Yes No Week#:				Do you now or have you ever experienced pain /	es 140	
						es No	
Are you nu	ırsing? Yes No				disconnort in your jaw joint (Tivis / Tivis):	es 110	
Have	e you ever had any of the follow		r medio	cal	Your current dental health is: Good Fair Poor		
	problems? (Please circle opt	ion that applies)			Do you like your smile?	es No	
0 00 0 0 00	emia / Radiation Treatment Y N	Hemophilia / Abnorr	mal Bleed	ling	Do your gums ever bleed?	'es No	
					How many times a week do you floss? a day do you brush?		
					Type of bristles? Hard Medium Soft		
Y N Blo	ood Transfusion Y N	Hospitalized for Any	Reason		Type of bristles: Flard infedium Soft		
Y N Ca	ncer / Chemotherapy Y N	Kidney Problems			Have you ever taken Phen-Fen? (also known as Redux or Pondimin)	es No	
ı	ngenital Heart Defect Y N	Mitral Valve Prolaps	e		[] ·		
	abetes Y N	Psychiatric Problem			If so when?		
_	ficulty Breathing Y N	Rheumatic / Scarlet					
	ug / Alcohol Abuse Y N nphysema / Glaucoma Y N	Severe / Frequent H Shingles	leadaches	S	I understand that the information that I have give	en today	
	ilepsy /Seizures / Fainting Spells Y N	Sickle Cell Disease	/ Troite	2.5%	is correct to the best of my knowledge. I also	_	
	ver Blisters / Herpes Y N	Sinus Problems	Trails		understand that this information will be held in		
	art Attack / Stroke Y N	Tuberculosis (TB)			strictest confidence and it is my responsibility t		
	1.43515415515 (1.2)			this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and			
Y N Hea							
ne) Cr	et any serious medical condition(s)) that you have e	ever had	q.	treatment with my informed consent.		
		- and you have t	, voi ma	u.	-		
	Are you allergic to any of the	ne following?			Signature Da	ate	
Y N Asp	pirin Y N Erythromyci	in Y N	Penicillir	n	Payment is due in full at the time of treatment unle	oce prior	
	deine Y N Jewelry / Me		Tetracyo		arrangements have been approved.	ss prior	
Y N Der	ntal Anesthetics Y N Latex	YN	Other		2 see althouses.		
Please list an	ny other drugs / material that you are allergic to	0 :			Thank you for filling out this form completely. It will enable help you more effectively. If you have any questions at a please ask us. We are happy to help.		
OFFICE USE	ONLY OFFICE USE ONLY OFFICE USE	ONLY OFFICE USE	ONLY	OFFICE U	SE ONLY OFFICE USE ONLY OFFICE USE ONLY		
I verbally reviewed the medical / dental information above with the patient named herein. Initials Date:							
	omments:						
1 Date:	0			L HISTORY			
1. Date:	San Spanish provide delay to take y						
	Comments:				• • • • • • • • • • • • • • • • • • • •		
L Date:	Comments:				Signature:		