Health History

Medical Conditions

_____ ADD/ADHD _____ AIDS/HIV Infection _____ Alcohol/Drug Abuse _____ Anemia

_____Arthritis _____ Artificial (Prosthetic) Heart _____ Artificial Joint(s) _____ Asthma

_____ Autism/Mental Health Condition(s) _____ Autoimmune Disease _____ Bleeding Problems

_____ Cancer _____ Cold Sores _____ Diabetes Type I or II _____ Eating Disorder

_____ Epilepsy/Seizures _____ Frequent dry mouth/Sjogren _____ GERD/Acid Reflux

_____ Heart Disease/Heart Attack _____ Hepatitis/Jaundice _____ High or Low Blood Pressure

_____ Liver or kidney disease _____ Lung/Breathing Issues _____ Neurological Disorders

_____ Osteoporosis _____ Rheumatic Fever _____ Rheumatoid Arthritis _____ Severe headaches/Migraines

_____ Sinus Trouble _____ Sleep disorder/Snoring _____ Stomach Issues _____ Thyroid Problems

_____ Tuberculosis _____Ulcers

Do you have any medical conditions that were not previously specified? Yes | No

If yes, please specify: _____

Allergies

_____ Amoxicillin/Penicillin _____ Aspirin _____Codeine/Narcotics _____ Dental Anesthetics

_____ Erythromycin _____ Latex/Rubber _____ NSAID _____ Sulfa

Do you have any allergies that were not previously specified? Yes | No

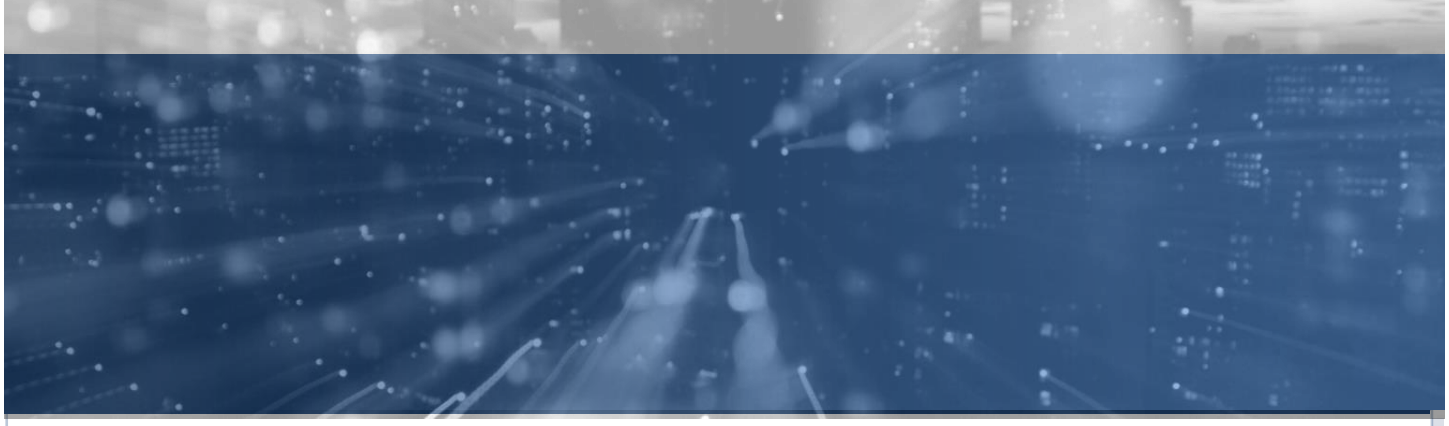
If yes, please specify: _____

Medications and Medical Devices

_____ Antibiotic Premedication _____ Birth Control _____ Blood Thinners

_____ Chemo/Radiation Treatment _____ Oral Bisphosphates _____Pacemaker _____ Wheelchair Bound

Please list all current medications: _____
_____



Medical History

Are you currently under the care of a physician? Yes | No

If yes, please provide the name and phone number of your physician: _____

Are you presently being treated for any injury or illness? Yes | No

Have you ever been hospitalized for an injury or illness? Yes | No

Are you currently breastfeeding, pregnant, or planning to become pregnant? Yes | No

Are you required to pre-med with antibiotics before dental treatment? Yes | No

How often do you consume alcohol?

- ☐ Never
- ☐ Very infrequently (1-2 times a month)
- ☐ Infrequently (Several times a month)
- ☐ Socially (1-2 times a week)
- ☐ Frequently (3-4 times a week)
- ☐ Very frequently (Almost daily)

Do you or have you ever used tobacco? Yes, currently | Yes, previously | No, never

Have you ever had an allergic reaction? Yes | No

Do you currently have or do you have history of head or neck injuries? Yes | No

Do you currently have, or do you have history of a medical condition or allergy that was not previously specified? Yes | No

Dental History

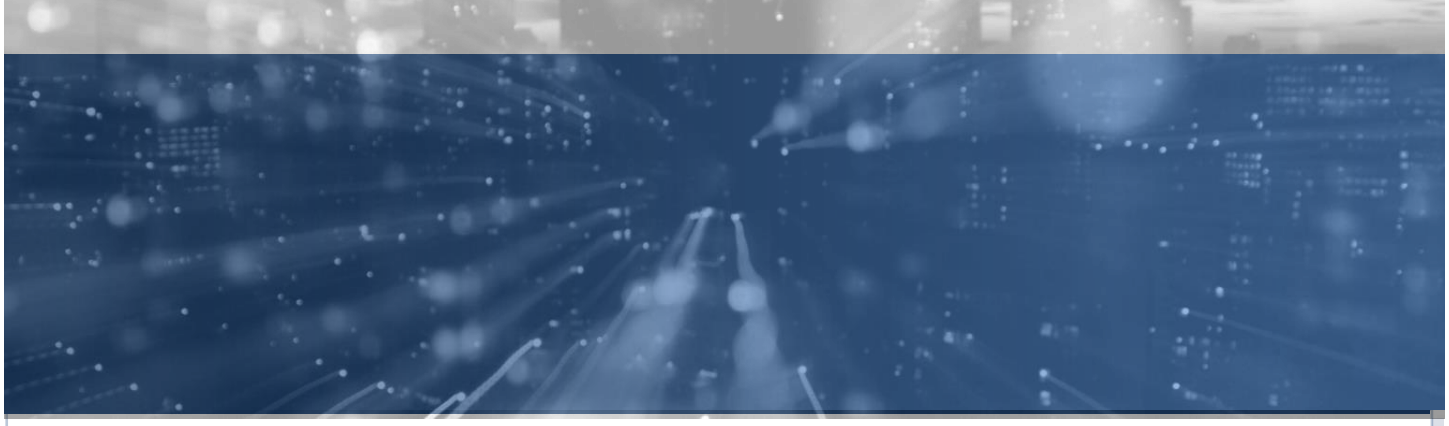
Who was your previous dentist? _____

Do you have any immediate concerns you would like us to address? Yes | No

If yes, please specify: _____

What do you value most in your dental visits? _____

Are you interested in improving your smile? Yes | No



Are your teeth sensitive to hot, cold, biting, and/or sweets? Yes | No

Do you clench your teeth during the day and/or nighttime? Yes | No

Do you bite your nails, chew gum, pens, or have any other oral habits? Yes | No

Do you often have a dry mouth or feel that the amount of saliva in your mouth is too little? Yes | No

Do your gums bleed when brushing or flossing? Yes | No

Have you ever been treated for or told you have gum disease? Yes | No

Have you ever had braces, clear aligners, or any other form of orthodontic treatment? Yes | No

Do you frequently get food caught between your teeth? Yes | No

Do you have any problems with your jaw joint? (TMD, popping or clicking, deviating from side to side while opening or closing) Yes | No

Signature: _____

Printed Name (if different than Patient): _____