

Dental History

Name _____ Date of last dental care _____

Reason for Today's Visit _____ Date of last dental x-rays _____

Check (✓) if you have had problems with any of the following:

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping/jaw pain	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores or growths in your mouth

How often do you brush/floss? _____ Do you have dental implants? Yes No

Is there anything you don't like about your teeth? _____

Is there anything else about having dental treatment that you would like us to know? _____

Medical History

Physician's Name (M.D.) _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionamin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(WOMEN) Are you pregnant? Yes No Nursing Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had problems with any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cold Sore	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cortisone Treatment	<input type="checkbox"/> Heart (Surgery, Disease, Attack)	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Depression	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Blood Disease/Bleeding Disorder	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Canker Sore	<input type="checkbox"/> Fainting	<input type="checkbox"/> Implants of any kind	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tobacco Use (Smoke/Chew)
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hay Fever/Sinus Problems	<input type="checkbox"/> Liver Disease/Jaundice	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Headache (severe/migraine)	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcer

<p style="text-align: center;">MEDICATIONS</p> <p>List any medications/natural remedies you are currently taking:</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">ALLERGIES</p> <p>Including medications, foods and latex.</p> <p>_____</p> <p>_____</p>
--	--

Do you have or have you had a disease, condition, or problem not listed? Yes No

If yes, please describe: _____

Patient Signature

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Medical History Reviewed	Date

Date: _____ Current Medications: _____

I have reviewed my/the patient MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write 'NO CHANGE"):

I Authorize LDA to contact my physician regarding pre-medication requirements. I confirm that I have taken required pre-medication one hour prior to appointment, or as directed by my physician.

Blood Pressure _____ Patient or Guardian Signature _____

Date: _____ Current Medications: _____

I have reviewed my/the patient MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write 'NO CHANGE"):

I Authorize LDA to contact my physician regarding pre-medication requirements. I confirm that I have taken required pre-medication one hour prior to appointment, or as directed by my physician.

Blood Pressure _____ Patient or Guardian Signature _____

Date: _____ Current Medications: _____

I have reviewed my/the patient MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write 'NO CHANGE"):

I Authorize LDA to contact my physician regarding pre-medication requirements. I confirm that I have taken required pre-medication one hour prior to appointment, or as directed by my physician.

Blood Pressure _____ Patient or Guardian Signature _____

Date: _____ Current Medications: _____

I have reviewed my/the patient MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write 'NO CHANGE"):

I Authorize LDA to contact my physician regarding pre-medication requirements. I confirm that I have taken required pre-medication one hour prior to appointment, or as directed by my physician.

Blood Pressure _____ Patient or Guardian Signature _____

Date: _____ Current Medications: _____

I have reviewed my/the patient MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write 'NO CHANGE"):

I Authorize LDA to contact my physician regarding pre-medication requirements. I confirm that I have taken required pre-medication one hour prior to appointment, or as directed by my physician.

Blood Pressure _____ Patient or Guardian Signature _____

Date: _____ Current Medications: _____

I have reviewed my/the patient MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write 'NO CHANGE"):

I Authorize LDA to contact my physician regarding pre-medication requirements. I confirm that I have taken required pre-medication one hour prior to appointment, or as directed by my physician.

Blood Pressure _____ Patient or Guardian Signature _____

Date: _____ Current Medications: _____

I have reviewed my/the patient MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write 'NO CHANGE"):

I Authorize LDA to contact my physician regarding pre-medication requirements. I confirm that I have taken required pre-medication one hour prior to appointment, or as directed by my physician.

Blood Pressure _____ Patient or Guardian Signature _____