DENTAL-MEDICAL HISTORY

The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment, READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE.

1. When was the last time you have seen a dentist? ______________ Had a cleaning/check-up?______________
2. What is your impression of your present health? ______________
3. Is there anything about your smile that you want to change? ______________
4. Are you interested in whitening your teeth? ______________
5. Do you have a history of:

CHECK YES OR NO FOR THE FOLLOWING QUESTIONS. IF "YES," PLEASE EXPLAIN.

	YES	NO		YES	NO		YES	NO
Heart Murmur	❑	❑	Hepatitis	❑	❑	Convulsions	❑	❑
Heart Condition	❑	❑	Diabetes	❑	❑	Venereal Disease	❑	❑
Heart Surgery	❑	❑	Anemia	❑	❑	Glaucoma	❑	❑
Rheumatic Fever	❑	❑	Kidney Disease	❑	❑	complications of Pregnancy	❑	❑
Frequent Chest Pains	❑	❑	Thyroid Disease	❑	❑	Stroke	❑	❑
High Blood Pressure	❑	❑	TB (Tuberculosis)	❑	❑	Arthritis	❑	❑
Shortness of Breath	❑	❑	Implant Prosthesis	❑	❑	Psychiatric Treatment by Whom______	❑	❑
Asthma	❑	❑	Cancer	❑	❑	HIV	❑	❑
Radiation Therapy	❑	❑	Lung Disease	❑	❑	AIDS	❑	❑
Liver Disease	❑	❑	Hives, Skin Rashes	❑	❑			
		❑	Swelling of Ankles	❑	❑			

	YES	NO
6. Are you presently, or have you been under the care of a physician during the past year? If yes, please explain: ______________	❑	❑
7. Are you presently taking any medicine or drugs? If yes, please explain: ______________	❑	❑
8. Are you allergic to any medicine or drugs? If yes, please explain: ______________	❑	❑
9. Have you ever had a reaction to a local anesthetic? If yes, please explain: ______________	❑	❑
10. Have you ever had instances of prolonged or unusual bleeding? Do you bruise easily? If yes, please explain: ______________	❑	❑
11. Have you ever experienced any complications or illness following dental treatment? If yes, please explain: ______________	❑	❑
12. Do you have any other disease, conditions or problems not listed above that your dentist should know about before proceeding with treatment? If yes, please explain: ______________	❑	❑
13. Are you pregnant? If yes, please circle trimester block: 1st Trimester 2nd Trimester 3rd Trimester	❑	❑

Signature of patient (or Legal Guardian) ______________ **Date** ______________

Dentist Remarks:

Signature of Dentist ______________ Date ______________