Dental History

Any present problems with your teeth? ______________________________

Any problems with bleeding gums? ______________________________

Date of last cleaning/exam: ______________________________

Previous Dentist's name and address: ______________________________

Medical History

Physician ______________________________

Address ______________________________ phone ______________________________

Please circle any condition(s) you have presently or had:

ASTHMA	HEART MURMUR	RHEUMATIC FEVER	ANEMIA	PACEMAKER
KIDNEY FAILURE	MITRAL VALVE PROBLEM	ARTHRITIS	DIABETES	CANCER
HIGH BLOOD PRESSURE	TUBERCULOSIS	HEART ATTACK	STROKE	EPILEPSY
	HEPATITIS/LIVER PROBLEM	THYROID DISORDER	BRONCHITIS	

Any problems with excessive bleeding from a cut? ______________________________

Do you have frequent infections? ______________________________

Do you drink or smoke? ______________________________

Are you pregnant (or suspect you may be)? ______________________________

Have you ever been hospitalized? ______________________________

Do you have any allergies (include any medications) ______________________________

List any medications you are taking: ______________________________

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Any other condition not mentioned above? ______________________________

I certify that the information above is accurate to the best of my knowledge.

X ______________________________

signature of patient (if minor, parent's signature) date

Reviewed by: ______________________________ Date: ______________________________