MEDICAL HISTORY

This information helps us to provide quality professional care and is strictly confidential.

Name _____

Medical Doctor's Name _____ Phone _____

Date of last physical exam _____ Are you currently being treated? _____

If so, what is the condition being treated? _____

Are you in good health? ☐Yes ☐No Have you had any serious illness or operation? ☐Yes ☐No

If so, what was the illness or operation? _____

Are you allergic to, or have you been adversely affected by any of the following? (please circle)

Aspirin	Foods	Nickel/Any Metals	Tetracycline
Barbiturates	Iodine	Nitrous Oxide	Tylenol
Codeine	Latex	Penicillin	Other _____
Erythromycin	Local Anesthetic	Sulfa Drugs	_____

Do you now have, or have you ever had, any of the following conditions? (please circle)

Anorexia/Bulimia	Chemical Dependency	Heart Surgery/Pacemaker	Psychiatric Condition
Ankles Swelling	Congenital Heart Problems	Hepatitis (A, B, C, other)	Rheumatic/Scarlet Fever
Anemia	Diabetes	High Blood Pressure	Seizures
Arthritis	Drug IV User	HIV/AIDS	Stroke
Artificial Heart Valve	Emphysema	Kidney Trouble	Stomach Ulcers
Artificial Joint	Epilepsy	Osteoporosis	Thyroid Problems
Asthma	Excessive/Abnormal Bleeding	Persistent Cough	Tobacco Habit
Blood Transfusion	Hay Fever	Persistent Diarrhea	Tuberculosis
Cancer	Heart Murmur	Phen/Fen Use	Venereal Disease
			Other_____

Are you taking any of the following? (please circle)

Antihistamines	Blood Thinners	Insulin or Similar Drug	Erythromycin
Aspirin	Cortisone	Hormone Therapy	Penicillin
Bisphosphonates (i.e. Fosamax)	Drugs for Heart Trouble	Nitroglycerin	Other Antibiotic
Blood Pressure Medicine	Tranquilizers	Oral Contraceptive	Other _____

Women:

Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Do you anticipate becoming pregnant? ☐Yes ☐No

Dental History

Former Dentist _____ Phone _____

Date of Last Dental Care _____ Date of Last x-rays _____

Please circle any of the following that may apply to your DENTAL conditions/concerns:

Toothache to hot, cold, chewing	Discolored teeth	Headaches/Neck pains	Chipped/Cracked teeth
Clicking or locking jaw	Missing permanent teeth	Loose teeth	Halitosis/Bad breath
Pain in jaw joints	Food packing between teeth	Dry Mouth	Crooked teeth
Troublesome wisdom teeth	Tooth Replacement (Implants)	Bleeding gums	Clench/Grind teeth
Want your mouth in perfect condition			

If residing in an area that does not enjoy the benefits of water fluoridation (such as Weber County), does your child currently take a fluoride supplement? ☐Yes ☐No

This information is complete and correct.

Signature _____ **Date** _____

Reviewed Date _____ Patient's Initials _____

_____ _____

_____ _____