

Medical Alert:

PATIENT

REASON FOR TODAY'S VISIT: _____

(PLEASE PRINT)

Male _____ Female _____

PATIENT NAME: FIRST _____ MI _____ LAST _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ WORK PHONE () _____ SSN # _____ - _____ - _____

E-MAIL _____ EMPLOYER _____

NAME OF PHYSICIAN & PHONE NO _____ DATE OF LAST PHYSICAL _____

HOW DID YOU HEAR ABOUT US _____

IN CASE OF EMERGENCY CONTACT _____ **PHONE** _____

DO YOU HAVE A HISTORY OF:

	YES	NO		YES	NO		YES	NO		YES	NO
A.I.D.S/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	LUPUS	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Are there any problems not listed that you would like to discuss?		
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>			
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>			

List any medications you are taking including non-prescription drugs

Are you allergic to any medications?

DENTAL INFORMATION

1. Date of last dental visit: _____

2. If wearing dentures, age of dentures: _____

	YES	NO
3. Do your gums bleed when brushing or eating	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you ever clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are your teeth sensitive to hot, cold, pressure?	<input type="checkbox"/>	<input type="checkbox"/>

On a scale of 1 – 10 with 10 being the highest rating:
How important is your dental health to you?

	1	2	3	4	5	6	7	8	9	10	YES	NO
If I could change my smile, I would make my teeth:												
Whiter											<input type="checkbox"/>	<input type="checkbox"/>
Straighter											<input type="checkbox"/>	<input type="checkbox"/>
Close space											<input type="checkbox"/>	<input type="checkbox"/>
Replace black mercury fillings with tooth colored restorations											<input type="checkbox"/>	<input type="checkbox"/>
Repair chipped teeth											<input type="checkbox"/>	<input type="checkbox"/>
Replace missing teeth											<input type="checkbox"/>	<input type="checkbox"/>
Less gum showing											<input type="checkbox"/>	<input type="checkbox"/>
Replace old crowns or caps that don't match											<input type="checkbox"/>	<input type="checkbox"/>
Do you prefer to save your teeth?											<input type="checkbox"/>	<input type="checkbox"/>

WOMEN	YES	NO
Is there a possibility of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Estimated delivery date _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
WOMEN NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.		

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors that I have made in the completion of this form.

Signature of Patient (parent or guardian if minor) _____ Date _____

Health History Reviewed by: _____ Dentist Signature _____