Personal Medical History

NAME______________________________________ **DOB**__________________ **SS#**______________________

Primary Physician_____________________ **Preferred Pharmacy & Location**______________________________

Please CIRCLE any of the following which you have had or have at present:

Heart Condition	Anemia or Hemophilia	Sinus Troubles	Thyroid Disease
Heart Attack or Stroke	Bruise Easily	Skin Rashes or Hives	Fainting or Dizziness
Heart Murmur	Shortness of Breath	Kidney Trouble	Arthritis or Rheumatism
Chest Pains	Swelling of Ankles	Diabetes	Pain in Jaw Joints
Heart Surgery	Artificial Joint	Sickle Cell Disease	Cold Sores (Fever Blisters)
Artificial Heart Valve	Lung Disease	Liver Disease	Alcoholism
Heart Pacemaker	Asthma or Hay Fever	AIDS	Drug Addiction
High Blood Pressure	Snoring	Blood Transfusion	Cancer or Tumor
Sleep Apnea	Jaw Clenching/Grinding	Epilepsy/Seizures	Radiation/Chemotherapy

Please list any diseases, conditions, or problems not listed above:

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Please list any ALLERGIES to medications:

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Do you have a known LATEX allergy? Yes_____ No _____

Please LIST all prescription and non-prescription medications you are currently TAKING (or request that we make a copy of your list in office.)

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Are you now under the care of a Physician other than for yearly check-ups?	**Yes No**
Have there been any changes in your health in the past year?	**Yes No**
Have you ever been hospitalized or had surgery ?	**Yes No**
Have you ever had a reaction to a local anesthetic?	**Yes No**
Have you ever experienced prolonged or unusual bleeding?	**Yes No**
Have you ever had complications or illness following dental treatment?	**Yes No**
Have you ever had an injury or trauma to your face or jaw?	**Yes No**
Do you smoke, vape or use smokeless (chewing) tobacco?	**Yes No**
Are you currently being treated for or have ever had a diagnosed eating disorder?	**Yes No**
Women: Are you pregnant now? If so, how many weeks gestation? _______	**Yes No**
Are you concerned about having dental work done?	**Yes No**
Are you happy with the way your smile looks?	**Yes No**

When was your last dental appointment? __________________Last x-rays? _________

Have you had any Periodontal (gum) treatments? Yes_____ No____

Treatment Desired (please circle):

Checkup Cleaning Cavities Restored Missing Teeth Replaced Orthodontics
Dentures Bonding Teeth Extracted Other: ________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have changes in my health, and/or medications, I will inform the office at my next appointment.

Signature_____________________________________**Date**___________________________