

About You

Name: _____
Last First Mr., Mrs., Ms., Dr.
Height: _____ Weight: _____
E-mail Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____
Wk#: (____) _____ Hm#: (____) _____

Medical History

Do you have a personal physician?..... Yes No
Physician's Name: _____
Wk#: (____) _____ Date of Last Visit: _____

Your current physical health is:..... Good Fair Poor
Are you currently under the care of a physician?..... Yes No
Please explain: _____

Are you taking any prescription medications/
over-the-counter drugs?..... Yes No
Please list each one: _____

Do you smoke or use tobacco in any other form?..... Yes No

For women: Are you taking birth control pills?..... Yes No

Are you pregnant?..... Yes No Week# _____

Are you nursing?..... Yes No

Have you ever taken Phen-fen?..... Yes No

If so, when? _____

Are you taking or scheduled to begin taking

Fosamax or Actonel?..... Yes No

If so, when? _____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any other drugs / materials that you are allergic to: _____

Dental History

What is the reason for your dental visit today? _____

Do you require antibiotics before dental treatment?..... Yes No

Are you currently in pain?..... Yes No

Have you ever had a serious/difficult problem associated with any previous dental work?..... Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)?..... Yes No

Have you ever had orthodontic treatment?..... Yes No

Do you like your smile?..... Yes No

Do your gums ever bleed?..... Yes No

Do you grind or brux your teeth?..... Yes No

Date of last dental exam & x-rays: _____

Have you ever had any of the following diseases or medical problems?
(Please circle option that applies)

Y N Anemia/Radiation Treatment	Y N Heart Surgery/Pacemaker
Y N Angina	Y N Hemophilia/Abnormal Bleeding
Y N Artificial Bones/Joints/Valves	Y N Hepatitis
Y N Arthritis	Y N High/Low Blood Pressure
Y N Asthma	Y N HIV/AIDS
Y N Autoimmune Disease	Y N Hospitalized in Past 5 Years
Y N Blood Transfusion	Y N Kidney Problems
Y N Cancer/Chemotherapy	Y N Mitral Valve Prolapse
Y N Cardiovascular Disease	Y N Osteoporosis
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes (Type I or II)	Y N Rheumatic/Scarlet Fever
Y N Difficulty Breathing	Y N Severe/Frequent Headaches
Y N Drug/Alcohol Abuse	Y N Shingles
Y N Emphysema/Glaucoma	Y N Sickle Cell Disease/Traits
Y N Epilepsy/Seizures/Fainting Spells	Y N Sinus Problems
Y N Fever Blisters/Herpes	Y N Tuberculosis (TB)
Y N Glaucoma	Y N Thyroid Problems
Y N GE Reflux/Persistent Heartburn	Y N Ulcers/Colitis
Y N Heart Attack/Stroke	Y N Venereal Disease
Y N Heart Murmur	

Please list any serious medical condition(s) that you have ever had: _____