MEDICAL INFORMATION - Do you have or (have you had) any of the following?

[] Heart problems or disease
[] High blood pressure
[] Pacemaker
[] Circulatory problems
[] Stroke
[] Heart murmur
[] Rheumatic fever
[] Anemia/bleeding disorder
[] Headaches – frequent or severe
[] Radiation therapy
[] Kidney problems
[] Congenital heart disorder
[] Heart attack/Heart failure
[] Mitral valve prolapse
[] Asthma
[] Sinus problems
[] Sleep apnea
[] Ulcer
[] Arthritis
[] AIDS/HIV positive
[] Artificial joint/hip replacement
[] Artificial heart valve
[] Anxiety/panic disorder
[] Psychiatric care
[] Hepatitis A, B or C
[] Drug/alcohol addiction
[] Epilepsy or seizures
[] Diabetes
[] Malignancy (cancer)
[] Premedication required?

Do you have any disease, condition or problem not listed above that you think we should know about?
Please explain: ____________________

Are you allergic to or (have you had) a reaction to:

[] Local anesthetics
[] Sulfa drugs
[] Codeine/ or other narcotics
[] Other: ____________________
[] Latex (rubber)
[] Food
[] Metals
[] Aspirin
[] Penicillin or other antibiotics
[] Hay fever/seasonal
[] Acetaminophen
[] Ibuprofen

Please list all medications you are currently taking:

____

During the past twelve months, have you taken any of the following?

[] Antibiotics
[] Sulfa drugs
[] Anticoagulants
[] Nitroglycerin
[] Coumadin
[] Warfarin
[] Plavix
[] Digitalis
[] High blood pressure medicine
[] Insulin, Orinase or similar drug
[] Controlled substances
[] Ibuprofen
[] Cortisone (steroids)
[] Natural remedies
[] Aspirin
[] Osteoporosis medication

For Women: Are you pregnant? [] Yes [] No How many weeks? _______ Are you nursing? [] Yes [] No
Are you taking birth control pills or hormone replacement? [] Yes [] No

Physician Name: ____________________ Phone: ______________ Date of last physical: ___________
Address: ____________________ City: ______________ State: _____ Zip: ___________

DENTAL INFORMATION

When was your last dental visit? ______________ Were x-rays taken? [] Yes [] No
Name of previous dentist: ____________________ Phone: ______________
What is your primary concern? ____________________

Have you ever had trouble getting numb or had reactions to local anesthetic? [] Yes [] No
Do your gums bleed or feel tender or irritated? [] Yes [] No
Have you ever had any periodontal (gum) treatments or deep cleaning? [] Yes [] No
Do you have cold sores or ulcers in your mouth? [] Yes [] No
Does food collect between your teeth? [] Yes [] No
Do you have any clicking, popping or discomfort in the jaw? [] Yes [] No
Do you clench or grind your teeth frequently? [] Yes [] No
Are your teeth sensitive to: hot, cold or sweets? [] Yes [] No
Are you satisfied with the appearance of your teeth? [] Yes [] No
Have you ever had a serious injury to your head or mouth? [] Yes [] No
Do you use tobacco (smoking, snuff or chew)? [] Yes [] No
Have you had any problems associated with previous dental treatment? [] Yes [] No
Have you had orthodontic (braces) treatment? [] Yes [] No