Medical History

Physicians name _____ _____ Date of last physical exam_____
Has there been any change in your general health in the past year? _____
Are you currently under the care of a physician? ___ If yes, for what reason? _____
Please list any prescription medications you are currently taking: _____
Do you smoke or use tobacco products Yes ___ No ___ If Yes, how much per day use? _____

Women: Are you: **Pregnant? Yes ___ Months___ no ___ Nursing? ___ Taking birth control pills? ____**

Do you have, or have had, any of the following: (Please check)

__ ANEMIA	__ HAY FEVER	__TESTED HIV +
__APPETITE CHANGED	__ HEPATITIS	__ THIRSTY OFTEN
__ ANY HEART PROBLEMS	__HERPES	__ TUBERCULOSIS
__ ARTHRITIS/ BURSITIS	__MALIGNANCIES	__ TYPHOID FEVER
__MEASLES	__VENEREAL DISEASE	__COSMETIC SURGERY
__ ASTHMA	__ MUMPS	__ ANESTHETIC ALLERGIES
__ HIGH BLOOD PRESSURE	__ NERVOUS PROBLEMS	__ PENICILLIN ALLERGY
__ LOW BLOOD PRESSURE	__ PSYCHIATRIC CARE	__ ALLERGIES (to other medications)
__ CIRCULATORY PROBLEMS	__ RADIATION TREATMENT	__ LATEX SENSITIVITY
__ RHEUMATIC FEVER	__SCARLET FEVER	__ DIABETES
__ EXCESSIVE BLEEDING	__ STROKE	__ SINUS PROBLEMS
__ FAINT EASILY	__ SKIN DISEASE	__ EPILEPSY

__ HOSPITALIZED LAST 5 YEARS IF SO, WHEN? _____ WHY? _____
__ HAVE YOU EVER BEEN PREMEDICATED BEFORE DENTAL TREATMENT?
OTHER INFORMATION WE SHOULD KNOW ABOUT YOUR GENERAL HEALTH:

DENTAL HEALTH & APPEARANCE (Circle Yes or No or Non-Applicable)

Are you having discomfort at this time? ....Yes/No
Have you been to a dentist in the last 6 months? .....Yes/ No
Have you lost any teeth other than wisdom teeth? .....Yes/No
Have you ever had missing teeth replaced? .....Yes/No/NA
Have you had any complications with a tooth removal? .....Yes/No/NA
If you have had teeth replaced, are you happy with the results? .....Yes/ No/NA
Are your teeth sensitive to heat, cold, sweet, sour, or when chewing... .....Yes/No
Have you ever had your teeth straightened or had orthodontics (braces) in the past? ..... .Yes/No
Do your gums bleed? .....Yes/No
Have you ever had treatment for gum problems? .....Yes/No
Do you ever feel (or have been told) that you don't have fresh breath? .....Yes/ No
Do you clench your teeth during the day or suspect you do during sleep? .....Yes/ No
Do you have any pain in, or around, your ears? .....Yes/No
Are you aware of any swelling or lumps in your mouth? ....Yes/ No
Do you ever experience a burning sensation in your mouth? .....Yes/ No
Have you ever had professional instructions on home dental care? ....Yes/ No
How do you feel about dental visits? (Circle one) *Relaxed* *Anxious* *Neutral*
Are you familiar with sedation and relaxation methods that can be combined with dental treatment? .....Yes/No
Are your teeth as white as you would like? .....Yes/No
Have you ever considered (or discussed) improving the appearance of your smile? .....Yes/No
How often do you brush your teeth? .....
How often do you floss your teeth? .....
Please list the obstacles that have prevented you from achieving your oral health and appearance goals in the past

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify Dr. Singer of any change in my health or medication.

*Patient/Guardian Signature*_____ *Date* _____