# Medical History

Patient Name: ____________________________

**Please circle (Y) for "yes" or (N) for "no" for any of the following which may apply to you now or in the past:**

| | | | |
|---|---|---|---|
| Y N Heart attack / Chest Pain | Y N Implant or Artificial Joint | Y N Thyroid Disease | Y N Headaches or Migraines |
| Y N Heart Disease | When? _____________ | Y N Asthma | Y N Epilepsy or Seizures |
| Y N Pacemaker | Y N Anemia or Blood Disorder | Y N Ulcers, Reflux, Heartburn | Y N Cancer, Chemo, Radiation |
| Y N Heart Valve Disorder | Y N Excessive Bleeding | Y N Digestive Disorders | Y N Tuberculosis, Lung Problems |
| Y N Stroke | Y N Psychiatric Disorders | Y N Kidney or Liver Problems | Y N Hepatitis A B C D |
| Y N High Blood Pressure | Y N Mononucleosis | Y N Fainting or Blackouts | Y N AIDS or HIV Infection |
| Y N Diabetes | Y N Herpes | Y N Drug/Alcohol Dependency | Y N Use Tobacco? |

Y N Has your physician advised you to take antibiotics before dental treatment? Reason ___________________________________

**Periodontal disease has been linked to the following, do you have any family history of:** (circle any that apply)

Heart Disease Stroke Diabetes Early-Term Birth Cancer Dementia

(Women) Are you currently pregnant? ________________ If yes, when are you expecting? _________________

Have you had any surgeries or been hospitalized in the last 5 years? □ Yes □ No

If yes, please explain: ____________________________________________________________________________

Physician's name and phone: ______________________________________________________________________

Please list any allergic reactions to an anesthetic or drug such as **penicillin, sedatives, latex, aspirin, or metals**:

_____________________________________________________________________________________________

Please list any drugs, medications, or vitamins you are currently taking:

We offer a variety of services to enhance your comfort, and keep your smile beautiful. Please circle any service below you would like our friendly team to discuss with you during your visit.

| | | |
|---|---|---|
| Whitening/Bleaching | Veneers | Invisalign (clear braces) |
| Traditional Braces | Implants | Replace Missing Teeth |
| Headache/Migraine Therapy | Sedation | |
| Night/Sports/Snoring Appliances | | |

Responsible Party Signature: ___________________________________________________ Date: ___________

Doctor/Hygienist Signature: ____________________________________________________ Date: ___________