



# Medical Form

To serve you properly we will need the following information. All information will be strictly confidential. Please print.

## Current Medical Condition

(Women only) Are you pregnant? \_\_\_\_ (Women only) If yes, what's the due date? \_\_\_\_\_

Family Doctor name (if you have one): \_\_\_\_\_ Doctor's Phone# (if available): \_\_\_\_\_

Are you being treated for any medical condition at the present? YES NO

If yes, what condition(s) is(are) being treated?: \_\_\_\_\_

Have you been ever hospitalized or had a serious illness? YES NO

If yes, explain: \_\_\_\_\_

Have you ever had excessive bleeding following an extraction, or do cuts take longer go heal now than previously? YES NO

## Medical History

Indicate which of the following you have had, or have at present. Circle 'Yes' or 'No' to each item.

### Nose

Frequent Nose Bleeds YES NO  
Sinus Problems YES NO

### Nervous System

Stroke YES NO  
Headaches YES NO  
Convulsions/Epilepsy YES NO  
Numbness/Tingling YES NO  
Dizziness/Fainting YES NO  
Psychiatric Treatment YES NO

### Endocrine

Diabetes YES NO  
Hypoglycemia YES NO  
Thyroid Condition/Goiter YES NO

### Throat

Soreness/Hoarseness YES NO

### Respiratory

Tuberculosis YES NO  
Emphysema YES NO  
Asthma/ Hay Fever YES NO  
Persistent Cough YES NO  
Difficulty breathing while laying down YES NO

### Heart/Blood Vessels

Rheumatic Fever YES NO  
Heart Murmur YES NO  
Chest Pain/Discomfort YES NO  
Heart Attack YES NO  
Shortness of Breath YES NO  
Swelling of Ankles YES NO  
High Blood Pressure YES NO  
Congenital Heart Disease YES NO  
Mitral Valve Prolapse YES NO  
Artificial Heart Valve YES NO  
Pacemaker YES NO  
Heart Surgery YES NO



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**Bone/Muscles**

Arthritis/ Rheumatism YES NO  
Artificial joints/Limbs YES NO

**Blood**

Bruise Easily YES NO  
Anemia YES NO  
Blood Transfusion YES NO

**Other**

Radiation/Chemotherapy YES NO  
Dizziness YES NO  
Sickle Cell Disease YES NO  
Neurological Disorders YES NO  
Latex Sensitivity YES NO  
AIDS/HIV YES NO  
Trigeminal Neuralgia YES NO  
Neck Ache YES NO  
Cancer YES NO  
Tumors or growths YES NO

**Allergies**

Local Anesthetics (eg. Novocaine) YES NO  
Barbiturates/Sedatives/Sleeping Pills YES NO  
Penicillin / Other Antibiotics YES NO  
Aspirin or Codeine YES NO  
Sulfa Drugs YES NO  
Other (please list) \_\_\_\_\_

**Are You Taking any of the Following?**

Antibiotics/Sulfa Drugs YES NO  
Blood Thinners YES NO  
Blood Pressure Medication YES NO  
Thyroid Medicine YES NO  
Antihistamines/ Allergy Drugs/Cold Remedies YES NO  
Insulin/Other Diabetes Drugs YES NO  
Recreational Drugs (i.e. Marijuana, Cocaine) YES NO  
Digitalis/Other Heart Medications YES NO  
Nitroglycerin YES NO  
Aspirin YES NO

Are you on any medication? YES NO  
If yes, please specify \_\_\_\_\_

Do you use tobacco in any form? YES NO If yes, how much? \_\_\_\_\_

Do you have more than 2 alcoholic drinks per day? YES NO

**Digestive System**

Hepatitis YES NO  
Liver disease/Jaundice YES NO  
Ulcers YES NO

**Urinary**

Kidney Trouble YES NO  
Venereal Disease YES NO



Dental Condition

Have you ever had any trouble associated with a previous treatment? YES NO
Does dental treatment make you nervous? (please circle) No Slightly Moderately Extremely
Have you ever been treated for periodontal disease (gum disease)? YES NO
If so, when? \_\_\_\_\_

Indicate which of the following you have had, or have at present. Circle 'Yes' or 'No' to each item.

Mouth

Bleeding, Soft Gums YES NO
Unpleasant Taste/Bad Breath YES NO
Burning Tongue/Lips YES NO
Frequent Blisters (Lips/Mouth) YES NO
Swelling / Lumps in Mouth YES NO
Ortho Treatment (Braces) YES NO
Clicking/Popping Jaw YES NO
Difficulty opening or closing Jaw YES NO

Teeth

Teeth Sensitivity YES NO
Facial Pain YES NO
Difficulty Chewing YES NO
Difficulty Swallowing YES NO
Does food pack or catch between your teeth? YES NO
Clenching YES NO
Grinding YES NO
Shifting in teeth YES NO

How often do you use dental floss? \_\_\_\_\_
How often do you brush your teeth? \_\_\_\_\_

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 health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_