

Current Family Physician: _____ Physician's Phone # _____

Are you currently under the care of a physician? []Yes []No

For what condition are you being treated? _____

Pharmacy of choice: _____ Pharmacy Phone # _____

Please list your medications below

Medication Name	Reason for Taking Medication	Medication Name	Reason for Taking Medication

Have you ever been treated for cancer with radiation or chemotherapy? []Yes []No

If so when and what area? _____

Are you allergic to medications, latex gloves, local anesthetics, etc.? _____ If so, what? _____

Are you subject to fainting spells: []Yes []No

Does your medical history include any of the following conditions?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Presently Pregnant | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

Please list any **other** medical problem you may have or had. _____

Do you use tobacco products? _____ If so, what and how much _____

Dental History: Are there any dental problems you would like addressed? _____

Which do you consider most important? ___preserving natural teeth ___eliminate pain ___appearance of your smile ___eliminate infection

What is your reaction to having dental treatment? ___enjoy the experience ___do not mind it ___dread it ___worry about it

When was your last dental appointment? _____ Purpose of last dental appointment? _____

How often do you brush your teeth? _____ What do you use to clean between your teeth? _____

What texture of toothbrush? ___soft ___med. ___hard Do you use an electric or manual toothbrush? _____

Please check any of the following habits, conditions or concerns you have:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/>]bleeding gums | <input type="checkbox"/>]missing permanent teeth | <input type="checkbox"/>]appearance of teeth | <input type="checkbox"/>]sensitive teeth |
| <input type="checkbox"/>]facial muscle pain | <input type="checkbox"/>]tender or swollen gums | <input type="checkbox"/>]clinch or grind teeth | <input type="checkbox"/>]existing cavities |
| <input type="checkbox"/>]tired jaws | <input type="checkbox"/>]broken teeth or fillings | <input type="checkbox"/>]frequent headaches | <input type="checkbox"/>]gag easily |
| <input type="checkbox"/>]"sweet tooth" | <input type="checkbox"/>]chew ice | <input type="checkbox"/>]chew hard crunchy foods | |
| <input type="checkbox"/>]history of gum surgery | <input type="checkbox"/>]history of radiation or chemotherapy for cancer related problems | | |

Please add anything you feel is important that will help our office serve you better: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health or information provided, I will inform this office's staff at the next appointment without fail.

Signature of Patient (Parent or Guardian) **X** _____ Date _____