Patient Name	Medical Alert

Dental Health History

Name of Previous Dentist		Phone Number
Address		
Date of Last Visit	Purpose of Last Visit	

Please Circle *Yes* or *No* to the following Questions

Are you apprehensive about dental treatment?	Yes	No	Do your gums bleed easily?	Yes	No
Have you had problems with previous dental treatment?	Yes	No	Do you gag easily?	Yes	No
Are your teeth sensitive to hot, cold, sweet, sour foods?	Yes	No	Do you take fluoride supplements?	Yes	No
Have you ever had trauma involving your teeth or jaws?	Yes	No	Do you have difficulty chewing?	Yes	No
Do you catch food between your teeth?	Yes	No	Do you clench or grind your teeth?	Yes	No
Are you dissatisfied with the appearance of your teeth?	Yes	No	Do you have pain in your jaw joints?	Yes	No
Do you have slow healing sores in or around your mouth?	Yes	No	Do you wear full or partial dentures?	Yes	No

Medical Health History

Name of Medical Doctor		Phone Number
Address		
Date of Last Visit	Purpose of Last Visit	

Please Circle *Yes* or *No* to the following Questions

Are you taking any medications? Include birth control pills, over the counter medications, herbal remedies, and hormones.	Yes	No	If yes, please list
Do you have any allergies or have you had any allergic reactions to any medications, latex, metals, or other substances?	Yes	No	If yes, please explain
Do you smoke?	Yes	No	If yes, how many packs per day
Do you drink alcohol?	Yes	No	If yes, how many drinks in average week
Women: pregnant or nursing?	Yes	No	If yes, what is/was your delivery date

Please circle *Yes* or *No*, if you have, or have had any of these conditions.

Heart Surgery	Yes	No	Cancer or Tumors	Yes	No	Hepatitis / Liver Disease	Yes	No
Chest Pain / Shortness of Breath	Yes	No	Asthma	Yes	No	Tuberculosis / COPD	Yes	No
Artificial Heart Valve/ Stint/ Pacemaker	Yes	No	Diabetes	Yes	No	Stomach / Intestinal Issues	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	Frequent/Severe Headaches	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Epilepsy/ Seizures/ Fainting	Yes	No
Congenital Heart Disease	Yes	No	Drug Abuse History	Yes	No	Joint Replaced / Implants	Yes	No
Abnormal Bleeding	Yes	No	HIV Positive / AIDS	Yes	No	Arthritis / Back / Neck Pain	Yes	No
Blood Disease / Anemia	Yes	No	Herpes / Other STD	Yes	No	Kidney / Bladder Problems	Yes	No
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	Yes	No	If yes, please explain					

Patient / Guardian signature	Date	Doctor Signature