Caring Smiles
You'll love our care and your smile will show it!

Health History

Medical History: **(Page 1 of 2)**

In order to best address your dental needs, we need to know about your general health. Please answer the questions below. Leave the answer blank if you do not understand the question.

Check the box next to any condition you have ever experienced:

- ◯ Anaphylaxis or hives
- ◯ Dizziness / fainting spells
- ◯ Seizures
- ◯ Bleeding problems, bruising easily
- ◯ Serious head or neck injury
- ◯ Headaches
- ◯ Ringing in ears
- ◯ Dry mouth
- ◯ Cold sores or fever blisters
- ◯ Sinus problems

Check the box next to any condition you currently have, or have you ever had:

- ◯ Replacement heart valve
- ◯ Heart defects or heart disease
- ◯ High blood pressure
- ◯ Heart attack
- ◯ Pacemaker
- ◯ Stroke or hardening of the arteries
- ◯ Diabetes
- ◯ Thyroid or adrenal diseases
- ◯ Reflux or other stomach problems
- ◯ Asthma, emphysema, or other lung diseases
- ◯ Glaucoma or other eye disease
- ◯ Sleep apnea
- ◯ Recreational drug use
- ◯ Hepatitis or other liver diseases?
- ◯ Tumors or cancer
- ◯ Chemotherapy
- ◯ Radiation treatments
- ◯ Kidney or bladder diseases
- ◯ HIV or AIDS
- ◯ Psychiatric care
- ◯ Arthritis or rheumatism
- ◯ Artificial joint
- ◯ Complications from surgery
- ◯ Contact lenses
- ◯ Osteoporosis
- ◯ Tobacco use

Women only, check the box if you are:

- ◯ Pregnant or nursing
- ◯ Using birth control pills

Please list all drugs, medications, over the counter medicines, and natural remedies that you use:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any other diseases or medical problems that you have had or currently have that have not been covered on this form:

_____ _____ _____

_____ _____ _____

Medical History: **(Page 2 of 2)**

Check the box next to anything you are allergic or sensitive to:

- ◯ Antibiotics?
- ◯ Pain Medicines?
- ◯ Latex?
- ◯ Local anesthetics?
- ◯ Metals or acrylic?
- ◯ Detergents?

Please list all drug, medication, and food allergies:

_____ _____ _____

_____ _____ _____

Are you being treated by a physician now?

If yes, for what: _____

Physician's name: _____

Dental History:

Check the box if you currently have, or have you ever had:

- ◯ Noises or pain in your jaw joint
- ◯ Treatment for your jaw joints (TMJ)?
- ◯ Orthodontic treatment (braces)
- ◯ Periodontal (gum) disease
- ◯ Dental anxiety
- ◯ Difficulty getting numb
- ◯ Problems with previous dental treatment
- ◯ Snoring or sleep apnea

What is your main dental concern? _____

_____

What would you change about your smile? _____

_____

Name of previous dentist: _____ **Date of last dental visit:** _____

Consent

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health status, and or the medications that I am using.

_____ _____

Signature **Date**