Dental Art Designs
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Patient Name:_____ Date _____/_____/_____

MEDICAL HISTORY **(Please Circle YES or NO)**

1. Has there been a recent change in your health?.....YES NO
   If yes, please explain: _____
2. When was your last physical examination? _____
3. Are you under the care of a physician? ..... YES NO
   If yes, condition: _____
4. Have you been hospitalized or had a serious illness within the last 5 years? ..... YES NO
   If yes, what was the problem: _____
5. Do you have or have you had any of the following (Circle all that apply)?

Artificial Limb or Heart Valve	Arthritis or Rheumatism	Hepatitis or Liver Disease
Organ Transplant	Heart Murmur	Psychiatric or Emotional Disease
Asthma or Hay Fever	Kidney Problems	HIV and/or AIDS
Fainting Spells or Seizures	Sexually Transmitted Disease	Rheumatic Fever or Heart Problem
Tuberculosis	Pacemaker	Diabetes
Abnormal Bleeding or Blood Disorders	Radiation Therapy	High / Low Blood Pressure
Other _____		Controlled Substance or Alcohol

6. Do you have any difficulty breathing through your nose? ..... YES NO
7. Are you currently taking any medication ..... YES NO
   If yes, please list: _____
   _____
8. Are you allergic or do you have addictions to any drugs or medications (i.e. Penicillin, Codeine, Cocaine, Alcohol)? ..... YES NO
   If yes, please list: _____
   _____
9. Are you aware of any lumps in your mouth? ..... YES NO
10. Have you ever had a bad reaction to local or general anesthetic? ..... YES NO
11. Have you ever had excessive bleeding after tooth extraction? ..... YES NO
12. Do you have any disease, condition, or other problems not listed above that you think I should know about? ..... YES NO
    If yes, please describe: _____
13. Do you wish to discuss your medical history privately with the doctor? ..... YES NO
14. Physician's Name: _____ Phone: _____

WOMAN ONLY

1. Are you Pregnant? If so, how many months? ..... YES NO
2. Are you taking birth control pills? ..... YES NO
3. Are you breast feeding? ..... YES NO

DENTAL HISTORY

1. What concerns you most about your teeth? _____
2. Are you aware of any dental problems at this time? _____
3. When was your last dental visit? _____
4. When was the last time you had X-rays taken in a dental office? _____
5. When was your last dental cleaning? _____
6. Have you had any of the following treatments? Orthodontics (Braces), Endodontics (Root Canal), Periodontics (Gum Therapy)? ..... YES NO
   If yes, please specify _____
7. Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth? ..... YES NO
8. Are you aware of grinding or clenching your teeth? ..... YES NO
9. Do your gums bleed? ..... YES NO
10. Do you suffer anxiety or gagging during dental procedures? ..... YES NO
11. Do you or have you worn partials or dentures? ..... YES NO
12. Do you want to avoid dentures? ..... YES NO
13. Are you unhappy with the appearance of your teeth? .....YES NO
14. What changes would you make about your mouth? _____
15. Interest and Hobbies? _____

PATIENT SIGNATURE _____ **DATE** _____

PARENT or GUARDIAN SIGNATURE (if minor) _____ **DATE** _____