



Medical History

We know that these are tedious and annoying, but they are also important. So please take a deep breath and fill this out to the best of your ability. Thank you!

Please list any medical conditions that you have been, or are being treated for:

Please list any medications you are taking, the reason and the dosing:

Have you had any allergic or adverse reactions to any drugs? If so, please list the drug and your reaction:

Are you allergic to any metals or foods? If so, please list _____

Are you pregnant? If so, when is your due date? _____

Do you have a history of Tuberculosis or TB-like symptoms (chronic cough)? _____

Do you have any complications with wounds healing? _____

Do you have a history of substance abuse? _____

Please let us know if you have ever had any of the following: (please circle)

- artificial joint
- heart ailment
- damaged or artificial heart valve
- high blood pressure
- hepatitis
- respiratory (lung) disease
- stomach/intestinal disease
- cancer
- diabetes
- liver disease
- blood disease
- HIV positive
- kidney disease

Dental History

Are you having any dental problems? If so, please list them: _____

Do you have a level of anxiousness about the dentist that you would prefer nitrous oxide (laughing gas) or a sedative before treatment? _____

Is there anything about your smile that you would like changed? (tooth bleaching, braces, old fillings) _____

When were your last X-rays taken? _____

Signature _____

Date _____

Reviewed by _____ Date _____