

MEDICAL DENTAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

The following answers are for our records only and will be considered confidential.

Please Circle

Y N Are you currently under medical treatment?

If yes, please explain: _____

Y N Have you been hospitalized in the past five years?

If yes, please explain: _____

Y N Have you had any surgeries? _____

Y N **Heart surgery?** _____

Y N **Have you had any joint replacements, received implants or donors?**

Y N **Have you had any reactions to any medications?**

If yes, please explain: _____

Y N Are you currently taking any medications or drugs?

If yes, please explain: _____

Y N **Are you sensitive to metals, latex, or other materials?**

If yes, please explain: _____

Y N Are you pregnant? Due date _____

Your physician's name: _____

Have you ever had any of the following? If so, please circle.

Heart Disease

Pace Maker

HIV positive test

Arthritis

Liver/Kidney Disease

Stomach Disease

Hepatitis

Thyroid Disease

High Blood Pressure

Respiratory Disease

Tumors/Cancer

Heart Murmur

Tuberculosis

Venereal Disease

Radiation Therapy

Asthma

Stroke

Rheumatic Fever

Osteoporosis

Blood Disease

Emotional Disturbances

Epilepsy

Bone Infection

Diabetes

Please Circle

Y N Do you have a specific dental problem? _____

Y N Have you had local anesthetic? (Novocain)

Y N Do you have any sores, growths or spots in your mouth?

Y N Do you smoke? How much per day? _____

Y N Do you use smokeless tobacco? (Chew) _____

When was your last dental cleaning and exam? _____

Where was this service performed? _____

Are you happy with your smile? _____

Please tell us what you would like us to do to change your general oral condition.

Have you had any prior dental experiences that we should be aware of?

I hereby give my consent for dental procedures for myself or for _____ .

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by Dr. Greg Zlock and his supervised staff.

I certify that the above answers are true to the best of my knowledge.

Signature _____ Date _____

Thank you for your thorough completion of this medical history.

Please see next page.