



Dental and Medical History

What is the reason for your visit today?

Date of Last Dental Visit _____

Have you had previous orthodontic treatment? Yes No

Have you ever had any complications following dental treatment? Yes No If yes, please explain:

Have there been any injuries to your face, mouth or teeth?
 Yes No If yes, please explain:

Are you presently in any dental pain?
 Yes No If yes, please explain:

Do your gums bleed when you brush your teeth?

Yes No

Is any part of your mouth sensitive to temperature or pressure? Yes No

Do your teeth or jaws ever feel uncomfortable, or make any clicking or popping noises? Yes No

Do you clench your teeth during the day? Yes No

Have you ever been told that you grind your teeth?

Yes No

Have you ever experienced chronic ringing in your ears?

Yes No

Do you have 'tension' headaches? Yes No

Do you have blisters or sores on your lips and/or in your mouth? Yes No

Do you ever have a burning sensation on your tongue?

Yes No

Do you smoke cigarettes, cigars, a pipe, etc. or use any tobacco product? Yes No

Do you consider yourself to be in good general health at this time? Yes No

Are you currently under the care of a physician?

Yes No If yes, please what is being treated?:

Name, location, and phone number of current physician:

Are you currently taking any medications, vitamins, supplements?

Yes No If yes, please describe:

Have you ever taken the drug Phen-fen and/or Redux?

Yes No If yes, when?: _____

Are you allergic to any medication including, but not limited to: Codeine, Penicillin, Tetracycline, Sulfa Drugs, Aspirin, or any other medication?

Yes No If yes, please explain:

Do you have any other allergies?

Yes No If yes, please explain:

Do you have a history or any major illness?

Yes No If yes, please explain:

Are you or have you ever taken Bisphosphonates for osteoporosis or cancer treatment?

Yes No If yes, when?: _____

Have you ever been involved in a serious accident?

Yes No If yes, please explain:

Have you been admitted to a hospital or needed emergency care during the past 2 years?

Yes No If yes, please explain:

Women Only:

Are you pregnant, or is there any chance you may be?

Yes No If yes, due date: _____

Are you nursing?

Yes No

If you checked either of the above and need to describe it, please do so here:



ARTISAN DENTAL

Cosmetic, Sedation and Implant Dentistry

Please check any of the following that you have had or currently have:

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Previous Infective Endocarditis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy or Fainting | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Rapid Weight Loss/Gain |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Headaches or Migraines | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Artificial Joints/Prosthesis | <input type="checkbox"/> Heart Problems, Heart Attack | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hepatitis/Liver Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Troubles |
| <input type="checkbox"/> Chemical/Drug Dependency | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Chest Pain upon Exertion | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes (Type I or II) | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumor or Cancer |
| <input type="checkbox"/> Dizziness or Seizures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pacemaker or Defibrillator | <input type="checkbox"/> Venereal Disease |

- Do you have any other disease, condition, or problem not listed above that you think we should know about?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient, Parent or Guardian

Date: _____