

### Medical History

Your overall health as well any medications which you are currently taking could have an important Interrelationship with the dental care you receive. Please answer the following questions completely.

Are you currently under a physicians care for any reason? (if yes, explain)

Do you have any drug allergies? \_\_\_\_\_

Do you have a latex allergy: Y / N                      Do you use tobacco products? Y / N

Female Patients

Are you pregnant at this time? Y / N

Are you taking birth control? Y / N

Please list all medications you may be taking and the reason.

Appr. Ht/Wt if under 12 years of age. \_\_\_\_\_

Y/N	Heart Trouble	Y/N	Heart Murmur	Y/N	Heart Disease
Y/N	Pace Maker	Y/N	High Blood Pressure	Y/N	Low Blood Pressure
Y/N	Diabetes	Y/N	Leukemia	Y/N	Asthma
Y/N	Aids/HIV	Y/N	Arthritis	Y/N	Anemia
Y/N	Emphysema	Y/N	Epilepsy	Y/N	Kidney Disease
Y/N	Thyroid	Y/N	Hepatitis	Y/N	Artificial Joints
Y/N	Ulcers	Y/N	Stroke	Y/N	Hay Fever
Y/N	Tuberculosis	Y/N	Liver Disease	Y/N	Rheumatic / Scarlet Fever
Y/N	Faint / Seizures	Y/N	Cancer	Y/N	Bleeding Disorders

Have you ever been told you needed to take pre-medication for any dental visits? Why?

### Dental History

What is the reason for todays visit? \_\_\_\_\_

Last dental visit \_\_\_\_\_ What was done? \_\_\_\_\_

Date of last x-rays \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Are you currently having any problems with your teeth? Explain

Y/N	Sensitivity to hot	Y/N	Sensitivity to cold	Y/N	Sensitivity to sweets
Y/N	Pain upon biting	Y/N	Swelling	Y/N	Mouth sores
Y/N	Bleeding gums	Y/N	Jaw joint pain		

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

Have you ever been seen by an Orthodontist? Y / N

Have you ever been seen by a Periodontist? Y / N

Do you wear a Full or Partial Denture? Y / N

Are you Happy with the color of your teeth? Y / N

Are you concerned with the straightness of your teeth? Y / N

If you wanted to change something about your smile what would it be?

I have completed this form to the best of my knowledge and give Dr. Asmar permission to diagnose and treat my current dental conditions.

Signature Patient/Guardian \_\_\_\_\_

Date \_\_\_\_\_