



MEDICAL & DENTAL HISTORY

Patient Name: _____ Preferred Name: _____
Phone _____ Email _____

1. Are you currently under the care of a physician? Yes No Physician's Name: _____
If yes, please explain: _____

2. Are you taking any prescription or over the counter drugs? Yes No
If yes, please list each one: _____

3. Do you bleed excessively when injured? Yes No

4. **For Women:** Are you pregnant? Yes No Are you nursing? Yes No
Are you currently taking birth control? Yes No

5. Please (check) either Yes or No for all conditions below that you have or have not had:

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>AIDS/HIV+</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>*Pre-Med</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>High Blood Pressure</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Arthritis</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Pacemaker</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Sinus Problems</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Asthma</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Liver Disease</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Siezuers</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Stroke</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Cancer</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Kidney Problems</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Vertigo</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Diabetes</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Low Blood Pressure</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Tuberculosis</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Hepatitis A/B/C</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Rheumatic Fever</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Heart Problem</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Epilepsy</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Other</u> |

6. If you (checked) YES to Heart Problem or Other, please explain: _____

7. Please (check) either Yes or No for all of the items listed below that you may or may not be allergic to:

- | | | |
|--|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Aspirin</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Penicillin</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Sulfa</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Erythromycin</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Tetracycline</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Dental Anesthetic</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Codeine</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Latex Gloves</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Acetaminophen</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Metals (Jewelry)</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Ibuprofen</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Other</u> |

8. Please list any other allergies: _____

9. What was your previous dentist's name? _____ Date of last visit? _____

10. Have you ever had Periodontal corrections; for example: Gum surgery/ Root Planing/ Deep Cleaning. Yes No.

11. Have you ever had Orthodontic appliances/ Braces/ etc.? Yes No.

12. Do your gums bleed after brushing or flossing? Yes No

13. Do you smoke or chew tobacco? Yes No If yes, how much and/or often? _____

14. Have you ever taken medication for Osteoporosis? Yes No If yes, what? _____

15. Have you had any type of implant placed or joint replacement in the last year Yes No If yes, what? _____

TREATMENT CONSENT

The answers that I have provided are true to the best of my knowledge. In addition, I authorize the doctors and staff of Global Smiles to provide me with routine dental care including but not limited to radiographs, photographs, diagnostic, prophylactic, preventative and restorative dental procedures.

X

Signature of Patient _____ Date _____ Guardian (if Under 18 Years of Age) _____ Date _____

Doctor's Signature: _____ Date _____