NAME _____ **DATE OF BIRTH** / /

Many medical situations affect (or may be affected by) the procedures/drugs used in dentistry. Therefore, please fill out the following information carefully. Thank you.

MEDICAL INFORMATION and HISTORY

Physician's name _____ Phone/location _____

When was your last medical examination? _____ Have you been seriously ill or hospitalized in the last two years? If yes, briefly explain. _____

HAVE YOU EXPERIENCED OR BEEN TREATED FOR any of the following? (Indicate yes with (X).

___ High blood pressure	___ Sinus Problems	___ Fainting/Dizziness	___ Venereal Disease	___ Kidney Problems
___ Excessive Bleeding	___ Tuberculosis	___ Epilepsy	___ Radiation Treatments	___ Thyroid Disorders
___ Anemia/Blood Problems	___ Emphysema	___ Stroke	___ Malignancies (cancer/tumors)	___ Ulcers/Colitus
___ Chest Pains	___ Rheumatic Fever	___ Neurological Problems	___ AIDS/Immunological Problems	___ Digestive Problems
___ Diabetes	___ Hay Fever	___ Psychiatric Care	___ Hepalitus/Liver Disorders	___ Arthritis
___ Any Heart Ailments	___ Pulmonary Problems	___ Emotional Problems	___ Vein/Artery Replacement	___ Artificial Joints
___ Heart Murmur	___ Mitro Valve Prolapse			

ARE YOU PRESENTLY: Pregnant? ___ Undergoing other medical treatment? (describe) _____

MEDICATIONS: Are you presently or regularly taking medications for:

___ High Blood Pressure ___ Antibiotics ___ Cortisone/Steroids ___ Sedatives or Tranquilizers ___ Blood Thinners

___ Other Medications _____

ALLERGIES/REACTIONS: Have you been made sick or had allergic reactions (itching, rash, swelling) to any foods or medications?

___ Novacaine Other _____

DENTAL INFORMATION and HISTORY

Dentist's name _____ Phone/location _____

When was your last dental cleaning exam? _____ Have you received instructions in the care of your teeth and gums? _____

Do you wear full or partial dentures? _____ Specifically on the use of dental floss? _____

HAVE YOU NOTICED: Any of the following (Indicate yes with (X))

___ Teeth tender to chew on	___ Frequent blisters on lips or mouth	___ Difficulty cleaning or flossing	___ Food impaction
___ Any sore areas in mouth	___ Pain in or around your ears	___ Other dental problem	___ Jaws Pop
___ Spaces developing between your teeth	___ Swelling or lumps in your mouth	___ Bleeding Gums	
___ Sensitivity to heat/cold, sweets or pressure	___ Clenching or grinding of teeth	___ Bad Breath	

WERE YOU TREATED by a

___ Periodontist (gums)
___ Orthodontist (braces)
___ Oral Surgeon

(COMMENTS) _____

What is the reason for your visit today? _____

Briefly describe what you feel your overall dental needs are? _____

Please note any sports, hobbies or special interests that you enjoy _____

To the best of my knowledge, these answers are correct. If there are any changes in my medical history or medications, I will notify Dr. Josiah Wagner at my next following appointment.

Signature _____ Dentist's Signature _____ Date _____

HEALTH HISTORY UPDATE

Signatures	Date	Additions