PERSONAL INFORMATION	
Name:	Address:
Date of Birth:	
	Postal Code
Family Doctor:	Home phone:
	Office phone:
How did you hear about our office:	Cell phone:
	Email:
	Where would you like us to contact you:
Occupation:	

MEDICAL HISTORY		
Please circle the appropriate answer	Yes	No
Have you been treated for any medical condition with in the last year?	Yes	No
Please list these conditions:		
When was your last medical check up?		
Are you taking any prescription medications?	Yes	No
Please list :		
Are you taking any non-prescription medication or herbal suppliments	Yes	No
Please list :		
Do you have any allergies?	Yes	No
Please list :		
Have you ever had a peculiar reaction to any medication?	Yes	No
Have you ever had a peculiar reaction to an injection?	Yes	No
Do you have asthma or breathing difficulties?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have an artificial joint?	Yes	No
Have you had heart surgery?	Yes	No
Have you been advised to take antibiotics before dental treatment?	Yes	No
Do you have any condition that could affect your immune system?	Yes	No
Have you had jaundice, hepatitis or any liver disease?	Yes	No
Do you have a bleeding disorder?	Yes	No
Do you take aspirin, Omega 3 or any other medication to thin your blood?	Yes	No
Have you ever been hospitalized for any illness or operations?	Yes	No
Please list:		
Do you smoke or chew tobacco products?	Yes	No
Are you currently trying to quit?	Yes	No
Are you interested in talking to us about quitting?	Yes	No
Are you nervous during dental treatment	Yes	No
What causes you the most concern?		
FOR WOMEN: Are you pregnant, trying to get pregnant or nursing?	Yes	No

Do you have or ever had:	a) chest pain or heart attack	Yes	No
	b) stroke	Yes	No
	c) tuberculosis or any other lung disease	Yes	No
	d) cancer	Yes	No
	e)steroid therapy	Yes	No
	f) diabetes	Yes	No
	g) arthritis	Yes	No
	h) osteoporosis	Yes	No
	i) fibromyalgia	Yes	No
	j) stomach ulcers or acid reflux	Yes	No
	k) seizures or epilepsy	Yes	No
	l) a neurological disorder	Yes	No
	m) kidney disease	Yes	No
	n) thyroid disease	Yes	No
	o) an eating disorder	Yes	No
	p) drug or alcohol addiction	Yes	No
Do you have any other diseases or conditions not listed on this form?		Yes	No
Please list :			
Are you completely happy with the appearance of your teeth?		Yes	No
If you were to change something what would that be?			
Do you get headaches?		Yes	No
Where on your head do they usually occur?			
How do you get rid of them?			
Do you suffer from migraines?		Yes	No
How often do they occur?			
How do you get rid of them?			
Have you ever been treated for TMJ dysfunction or any jaw problems?		Yes	No
Have you ever worn braces?		Yes	No
When and for how long?			
Did you have teeth extracted before the braces?		Yes	No
Do you stop breathing during sleep (sleep apnea)?		Yes	No
Are you being treated for sleep apnea?		Yes	No
Do you have a splint or night guard appliance?		Yes	No
How often do you wear it?			
Patient or Parent/Guardian	Date		
Dentist or Hygienist	Date		