Andrew J. Sorkin, D.M.D, L.L.C
Mark A. Wallace, D.D.S

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○Yes	○No	If yes, please explain_____
Have you ever been hospitalized or had a major operation?	○Yes	○No	If yes, please explain_____
Have you ever had a serious head or neck injury?	○Yes	○No	If yes, please explain_____
Are you taking any medications, pills or drugs?	○Yes	○No	If yes, please explain_____
Do you take, or have you taken, Phen-Fen or Redux?	○Yes	○No	_____
Are you on a special diet?	○Yes	○No	_____
Do you use tobacco?	○Yes	○No	**Women**: Are you
Do you use controlled substances?	○Yes	○No	□Pregnant/Trying to get pregnant? □Nursing?
			□Taking oral contraceptives?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics
□ Other: If yes, please explain: _____

Do you have, or have you had, any of the following?

□ Aids/HIV Positive	□ Chest Pains	□ Frequent Headaches	□ Irregular Heartbeat	□ Scarlet Fever
□ Alzheimer's Disease	□ Cold Sores/ Fever Blisters	□ Genital Herpes	□ Kidney Problems	□ Shingles
□ Anaphylaxis	□ Congenital Heart Disorder	□ Glaucoma	□ Leukemia	□ Sickle Cell Disease
□ Anemia	□ Convulsions	□ Hay Fever	□ Liver Disease	□ Sinus Trouble
□ Angina	□ Cortisone Medicine	□ Heart Attack/ Failure	□ Low Blood Pressure	□ Spina Bifida
□ Arthritis/Gout	□ Diabetes	□ Heart Murmur	□ Lung Disease	□ Stomach/Intestinal Disease
□ Artificial Heart Valve	□ Drug Addiction	□ Heart Pace Maker	□ Mitral Valve Prolapse	□ Stroke
□ Artificial Joint	□ Easily Winded	□ Heart Trouble/Disease	□ Pain in Jaw Joints	□ Swelling of Limbs
□ Asthma	□ Emphysema	□ Hemophilia	□ Parathyroid Disease	□ Thyroid Disease
□ Blood Disease	□ Epilepsy or Seizures	□ Hepatitis A	□ Psychiatric Care	□ Tonsillitis
□ Blood Transfusion	□ Excessive Bleeding	□ Hepatitis B or C	□ Radiation Treatments	□ Tuberculosis
□ Breathing Problem	□ Excessive Thirst	□ Herpes	□ Recent Weight Loss	□ Tumors or Growths
□ Bruise Easily	□ Fainting Spells/Dizziness	□ High Blood Pressure	□ Renal Dialysis	□ Ulcers
□ Cancer	□ Frequent Cough	□ Hives or Rash	□ Rheumatic Fever	□ Venereal Disease
□ Chemotherapy	□ Frequent Diarrhea	□ Hypoglycemia	□ Rheumatism	□ Yellow Jaundice

Dental Information:

Reason for today's visit: □ Exam □ Emergency □ Consultation
Are you in pain? □ No □Yes How long? _____
□ Discomfort, clicking or popping in jaw □ Lost/Broken Filling(s) □ Stained Teeth □ Locking Jaw
□ Teeth Grinding □ Red, swollen or bleeding gums □ Broken/Chipped Tooth/Teeth □ Ringing in Ears
□ Bad Breath □ Blisters/ Sores in or around the mouth □ Sensitive Tooth, teeth or gums
□ Other: _____ Do you require pre-medication? □ Yes □ No □ Don't Know
Previous Dentist: _____ (_____) _____
Name Phone #
Last Dental exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____ Times a day you brush? _____
Times a week you floss? _____ What type of tooth brush bristles do you use? □ Soft □ Medium □ Hard
How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____DATE _____