Name _____ Date _____
Last First MI

MEDICAL HISTORY

Physician's Name _____ Phone _____ Date of Last Physical _____

Have you ever had any of the following? (Please circle yes or no)

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Cancer	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what _____

_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what _____

Do you premedicate for dental appointments? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

_____

Do you have or have you had any disease, condition or problem not listed? ..... Yes No

If yes, please list: _____

Women. Are you: **Pregnant?** Yes _____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of changes in my health or medication.

Signature _____ Date _____

(Please complete other side)

LAWRENCE T. FOX, DDS

Cosmetic ◆ Laser ◆ Implant ◆ General

Dentistry

DENTAL HISTORY

What is the reason for your visit today? _____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-ray _____

What was done at your last dental visit? _____

Do you have any dental problems now? ☐ Yes ☐ No If yes, please describe _____

Are any of your teeth sensitive to: Hot? ☐ Yes ☐ No Cold? ☐ Yes ☐ No
Sweets? ☐ Yes ☐ No Biting or chewing? ☐ Yes ☐ No

How often do you brush? _____ Do you floss? ☐ Yes ☐ No How often? _____

Do your gums hurt or bleed? ☐ Yes ☐ No

Does food tend to get caught in between your teeth? ☐ Yes ☐ No

Have you ever had periodontal treatment? ☐ Yes ☐ No

Are you satisfied with the appearance of your teeth? (For example: color, shape, spaces, etc.) ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe _____

_____

(Please complete other side)