Health and Dental History

Have you been under the care of a medical doctor during the past two years? Yes No
If so, for what?_____
Physicians name_____Phone #_____
Are you taking any medication now, including regular dosages of aspirin? Yes No
If so, please list name and dosage_____
_____
Are you aware of having an allergic reaction to any medication or substance? Yes No
If so please list_____
Have you seen an ENT? Yes No
Have you seen a neurologist? Yes No

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart concerns	Yes	No	Headaches	Yes	No	Have you had braces?	Yes	No
Congenital heart disease	Yes	No	Jaw Pain	Yes	No	Do you see a chiropractor?	Yes	No
Heart murmur	Yes	No	Jaw popping	Yes	No	Does floss shred when you use it?	Yes	No
High blood pressure	Yes	No	Limited opening	Yes	No			
Mitral valve prolapse	Yes	No	Conjested ears	Yes	No	Does food pack or catch between your		
Artificial heart valve	Yes	No	Dizziness	Yes	No	teeth?	Yes	No
Pacemaker	Yes	No	Ringing ears	Yes	No	Do you smoke or use tobacco?	Yes	No
Stroke	Yes	No	Loose teeth	Yes	No			
Asthma	Yes	No	Posture problems	Yes	No	Do your gums bleed?	Yes	No
Liver disease/jaundice	Yes	No	Clenching	Yes	No	Does your breath concern you?	Yes	No
Latex sensitivity	Yes	No	Grinding	Yes	No			
Artificial joints	Yes	No	Facial pain	Yes	No	Past periodontal treatment?	Yes	No
Kidney trouble	Yes	No	Sensitive teeth	Yes	No			
Radiation/Chemo	Yes	No	Neck pain	Yes	No			
Epilepsy/seizures	Yes	No	Bell's Palsy	Yes	No			
Diabetes	Yes	No						
Hepatitis	Yes	No	Difficulty swallowing	Yes	No			
AIDS/HIV	Yes	No	Difficulty chewing	Yes	No			
Sickle Cell disease	Yes	No	Trigeminal neuralgia	Yes	No			
Neurological disorder	Yes	No	Insomnia/frequent waking	Yes	No			

Do you have or have you had any disease, condition or problem not listed?
_____

Women: Are you pregnant? _____ Nursing? _____Taking birth control pills?_____

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 who may release such information to you. I will notify the doctor of any change in my health or medication.
Signature_____Date_____

Social Security Number_____Date of birth_____

E-mail address_____
For more information, please visit our new website at www.dentistry-chicago.com

Remember to fax these back to our office at 773-631-7438, e-mail, or regular mail two days prior to your visit.