## MEDICAL HISTORY

Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your response to this questionnaire and there may be additional questions concerning your health.

Name of personal physician: _____

Phone # _____

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Please explain _____

_____

_____

Please list all medications you are currently taking .

_____

_____

Do you a smoke? ☐ Yes ☐ No

How much? Packs per day _____

Do you use smokeless tobacco products? ☐ Yes ☐ No

**Blood Pressure:**

Date: _____ _____

Date: _____ _____

**Please check if you had been treated for, the following diseases or medical problems.**

Heart Conditions:

- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Heart Bypass Surgery
- ☐ Mitral Valve Prolapse
- ☐ Congestive Heart Failure
- ☐ Heart Valve Replacement
- ☐ Pacemaker
- ☐ Hepatitis A__B__C__
- ☐ Epilepsy
- ☐ Cancer
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Stroke
- ☐ Anemia
- ☐ Abnormal Bleeding
- ☐ Ulcers/Colitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Sinus Problems
- ☐ Emphysema

Please list any other medical condition(s): _____

_____

_____

_____

_____

**Are you allergic to any of the following drugs?**

- ☐ Penicillin
- ☐ Latex
- ☐ Dental Anesthetics
- ☐ Codeine
- ☐ Ibuprofen/Motrin
- ☐ Tetracycline
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Sulfa

Please list any other drugs that you are allergic to ____

_____

_____

## DENTAL HISTORY

Why have you come to the dentist today? _____

The date of your last dental visit:_____ Previous Dentist's name _____

If you could wave a magic wand, and change anything about the appearance of your smile, what would you like to do?

_____

If you could easily and safely whiten your teeth, would you be interested? ☐ Yes ☐ No

Do your gums bleed when you brush? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No If yes explain _____

Photo release: In exchange for good and valuable consideration, the receipt and adequacy of which is acknowledged the undersigned, together with his/her heirs and assigns, grants to Westpark Dental the right and license to display photographs of the undersigned to advertising and/or similar commercial and educational purpose. The undersigned understands and agrees that such photographs will be displayed to and be viewed by, the patients, prospective patients, dental and office staff and other persons who may enter the office of the dentist.

Patient (parent / guardian if minor): _____ Date _____