

HEALTH HISTORY

Patient Name _____

Do you have any CURRENT HEALTH PROBLEMS? Yes No

Are you under a PHYSICIAN'S CARE now? Yes No

If so, for what condition? _____

Are you currently taking any MEDICATIONS? Yes No

If so, please list _____

Are you allergic to any medication? If so, please list _____

Please circle any of the following which apply now, or have applied in the past.

Heart Failure	High Blood Pressure	Stroke	Chemotherapy
Heart Disease	Smoker	Hemophilia	X-ray Treatment
Heart Murmur	Psychiatric Treatment	Diabetes	Nervousness
Heart Surgery	Ulcers	Liver Disease	Asthma
Artificial Heart Valve	Hepatitis A or B	Venereal Disease	Sinus Trouble
Artificial Joint	AIDS or HIV+	Arthritis	Allergies
Rheumatic Fever	Epilepsy	Anemia	Thyroid Disease
Kidney Problems	Tuberculosis	Drug Addiction	Jaw Pain
Yellow Jaundice			

Is there any additional Medical or Dental information we should know about? _____

Physician's Name: _____ Date of last visit: _____

DENTAL HISTORY

How long has it been since your last dental visit? _____

Last set of X-rays? _____

Name of previous dentist: _____ City: _____ State: _____

Are you unhappy with your teeth? _____

Do you floss regularly? _____ Do your gums bleed? _____

Have you had any periodontal (gum) treatment? _____

Have you had orthodontic (braces) treatment? _____

Have you ever had a bad dental experience? _____

I authorize Dr. Baemmert and staff to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Baemmert to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Baemmert to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk.

Patient, Parent or Guardian _____ Date _____