



**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_

Do you have a personal physician?  Yes  No Physician's name: \_\_\_\_\_

Physician's city or phone: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

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

Please explain: \_\_\_\_\_

Do you use tobacco in any form?  Yes  No

Have you had any metal rods, pins or implants placed? \_\_\_\_\_

Are you taking any medications?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever had any surgical procedures?  Yes  No

Please list each one: \_\_\_\_\_

- | Yes                      | No                       | Conditions              |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding       |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse           |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris         |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion       |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing    |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse              |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema               |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial Surgery          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells         |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters          |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches      |

- | Yes                      | No                       | Conditions                   |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                     |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV + AIDS                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery                |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C                  |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure          |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement            |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems              |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease                |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure           |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse        |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems         |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever              |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles                     |

- | Yes                      | No                       | Conditions          |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems      |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke              |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems    |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis        |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers              |

- | Yes                      | No                       | Allergies          |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin            |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine            |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin       |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry            |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex              |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals             |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin         |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline       |

- | Yes                      | No                       | If Female, Please Answer                     |
|--------------------------|--------------------------|----------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Birth Control Pills?          |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?<br>If so, # of Weeks _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing?                             |

Nearest relative not living with you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PATIENT DENTAL HISTORY**

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Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your current dental health is?  Good  Fair  Poor

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No

Have you ever had gum treatment?  Yes  No

Do you like your smile?  Yes  No

Is there anything you would change about your smile? \_\_\_\_\_

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Do your gums bleed?  Yes  No

Are your teeth sensitive to heat, cold, or anything else?  Yes  No

Have you lost any teeth?  Yes  No

Have you ever had a serious/difficult problem with any previous dental work?  Yes  No

Have you ever had any unfavorable dental experiences?  Yes  No

When was your last dental visit? \_\_\_\_\_

How can we accommodate you best during your dental visit? \_\_\_\_\_

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Here at Tim Loughran Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Zoom Tooth Whitening

Veneers/Lumineers

Bonding

Smile Makeover

Crown and Bridge

Implants

Denture Services