Medical History

Are you currently under the care of a physician? If yes, please describe.___________________________________

Are you currently taking prescription or OTC drugs of any kind? If yes, please list or attach a copy.____

Women Only: Are you pregnant, nursing or taking oral contraceptives?___________________________________

Do you have, have had, or been treated for, any of the following?

- ARTHRITIS
- RHEUMATIC FEVER
- HEART PROBLEMS
- HIGH/LOW BLOOD PRESSURE
- ANEMIA/SICKLE CELL
- EPILEPSY/SEIZURES
- CHEMICAL DEPENDENCY
- HEPATITIS A, B, OR C
- ULCERS
- KIDNEY DISORDERS
- HEMOPHILIA, BLEEDING DISORDER
- THYROID CONDITION
- VENEREAL DISEASE
- PACEMAKER
- JOINT REPLACEMENT, if yes date:__________
- RADIATION THERAPY
- CHRONIC SINUS INFECTION
- ASTHMA
- HEART MURMUR
- MITRAL VALVE PROLAPSE
- FAINTING SPELLS
- DIABETES
- AUTISM/SENSORY SENSITIVITY
- TUBERCULOSIS
- ANOREXIA/ BULIMIA
- AIDS RELATED COMPLEX
- PHEN-PHEN OR REDUX

Do you have any reactions to or are you allergic to:

- LOCAL ANESTHETICS
- ASPIRIN OR IBUPROFEN
- BARBITURATES OR TRANQUILIZERS
- CODEINE OR OTHER NARCOTICS
- LATEX
- PENICILLIN
- ERYTHROMYCIN
- ACETAMINOPHEN (Tylenol)
- SULFA DRUGS
- ANY OTHER MEDICATIONS
- If yes ______________

Why have you come to the dentist today? ____

Have you ever had more than a "regular cleaning"?____

How would you describe the condition of your teeth and gums on a scale of 1 to 10? ________________________

Are you currently in pain or discomfort with your teeth and gums?_____________________________________

If yes, please explain. ____

How often do you brush your teeth?___________________How often do you floss your teeth?________________

Do your gums bleed when you floss or brush your teeth? Y or N   Do you use tobacco products? Y or N

I understand that the information is correct to the best of my knowledge and it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the release of information for insurance purposes and give consent for Dr. Wescott and his staff to treat me. I authorize Dr. Wescott and/or his staff to take photos of my care and treatment, which may be used for the

advancement and educational viewing by other dentists, staff or patients. Dr. Wescott and his staff cannot reveal my identification without my permission. I am responsible for payment.

Signature:____Date:_______________________________________

(If under 18, parent or guardian)