Marci S. Morris, DDS "Creating Beautiful Smiles in a Family Atmosphere"

Medical History

☐ Yes ☐ No Do you smoke?

☐ Yes ☐ No Have you been admitted to the hospital or needed emergency care with in the last 5 years? If yes, please explain: _____

☐ Yes ☐ No (For women only) Are you pregnant/nursing? If yes, for how long? _____

☐ Yes ☐ No Are you currently under the care of a physician? If yes, please explain _____

Physician Name _____ Physician phone number _____

☐ Yes ☐ No Are you currently taking any medications? Please list below:

_____ _____ _____

_____ _____ _____

☐ Yes ☐ No Are you allergic to anything? _____

Please check the box below if you have or have had in the past any of the following:

☐ AIDS/HIV	☐ Cortisone treatments	☐ Hemophilia	☐ Rheumatic Fever
☐ Anemia	☐ Cough (persistent)	☐ Hepatitis	☐ Rheumatism
☐ Arthritis	☐ Cough up blood	☐ High Blood Pressure	☐ Sinus Problems
☐ Artificial Joints	☐ Diabetes	☐ Low Blood Pressure	☐ Stomach Problems
☐ Asthma	☐ Emphysema	☐ Jaundice	☐ Stroke
☐ Back Problems	☐ Epilepsy/Convulsions	☐ Kidney Disease	☐ Thyroid Problems
☐ Periodontal Treatment	☐ Fainting/Dizziness	☐ Bleeding Gums	☐ Tuberculosis
☐ Blood Disease	☐ Glaucoma	☐ Liver Disease	☐ Tumors
☐ Cancer	☐ Hay Fever/Allergies	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Chemical Dependency	☐ Heart Attacks	☐ Mental Disorder	☐ Radiation Treatment
☐ Chemotherapy	☐ Heart Disease	☐ Nervous Disorder	☐ Respiratory Problems
☐ Chest Pains	☐ Heart Murmurs	☐ Pacemaker	☐ **Premed** for dental work
☐ Circulatory Problems	☐ Heart Problems	☐ **Latex** allergy	☐ Venereal disease

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Dental History

Date of last dental visit_____ Date of last dental x-rays_____ Reason for last dental visit_____

☐ Yes ☐ No Are you having any pain? If yes, for how long? _____
☐ Yes ☐ No Do you floss? How many times a day do you brush/floss? _____
☐ Yes ☐ No Are you fearful of dentist/dental treatment?
☐ Yes ☐ No Have you had any complications following dental treatment? If yes, please explain:
_____

"To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever a change in my health or the health of my minor child, I understand it is my responsibility to inform the doctor at my next appointment without fail."

Signature of patient, parent or guardian _____ Date _____

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