HEALTH HISTORY

Smiles BY MORGAN

Dr. Michael J. Morgan
7 N. Grant Street
Hinsdale, IL 60521

DENTAL HISTORY

first name | last name | today's date

reason for today's visit

check if you have or have had problems with any of the following:

fear of dental treatment	periodontal treatment		
bleeding gums	food collection between teeth	mouth odors or bad tastes	sensivity to hot or cold
clicking or popping jaw	grinding teeth	oral surgery	sensivity to sweets
orthodontic treatment	cold sores or other lesions	loose teeth or broken fillings	sensivity when biting

are you satisfied with the appearance of your teeth?

would you like a whiter smile? | would you like straighter teeth?

MEDICAL HISTORY

are you currently under physician care? | if so, please explain

physician's name | phone

have you had any serious illnesses or operations? | if so, please explain

women: are you pregnant? | if so, how many months? | nursing? | taking birth control pills?

check if you have or have had any of the following:

anemia	cortisone treatments	hepatitis	rheumatic/scarlet fever
arthritis/rheumatism	cough persistent	high blood pressure	shortness of breath
artificial heart valves	cough up blood	hiv+/aids	sinus problems
artificial joints	diabetes	jaw pain	skin rash
asthma	epilepsy/seizures	kidney disease	stroke
back problems	fainting/dizziness	liver disease	swelling of feet/ankles
blood transfusion	headaches	pacemaker/heart surgery	tobacco habit
cancer/tumors	heart murmur	psychiatric care	tonsillitis
chemical dependency	heart problems	radiation treatment	tuberculosis
chemotherapy	hemophilia/abnormal bleeding	rapid weight gain or loss	ulcer
circulatory problems	herpes	respiratory disease	venereal disease

do you have or have had any disease, condition or problem not listed above? if so, explain

list medications you are currently taking

list allergies to any medications or substance including non-prescription medications and supplements.

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered every question on this form completely and accurately, to the best of my knowledge. I will inform my dentist of any change in my health and/or medication.

patient signature | date