LeJon M. Carreon, DDS

Medical/Dental Health

Name and Address of Physician: _____

Are you taking any prescription/over-the-counter drugs? _____

If yes, please list each one: _____

Are you allergic to any of the following drugs? ☐Penicillin ☐Aspirin ☐Erythromycin ☐Latex ☐Dental Anesthetics ☐Codeine ☐Tetracycline

Please list any other drugs that you are allergic to: _____

When was your last dental visit? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Have you ever been treated for: (please circle)

Abnormal Blood Pressure	Heart Attack		Heart surgery
Heart Murmur	Congenital Heart Lesions		Artificial Heart Valve
Heart Pacemaker	Congestive Heart Disease	Stroke	
Anemia	Rheumatic Fever		Diabetes
Epilepsy	Tuberculosis or Lung Disease	Ulcers	
Sinus Trouble	Asthma		Surgical Stints, Plates or Pins
Artificial Joints or Implants	Kidney Disease	Thyroid Disease	
Arthritis	Liver Disease	Hepatitis	
Drug Addiction	Psychiatric Treatment		Glaucoma
Cancer	Hemophilia		HIV or AIDS

Other physical conditions we should be aware of: _____

Do you clench or grind?.....☐yes ☐no

Are you a tobacco user?..... ☐yes ☐no

Have you ever been treated with radiation?.....☐yes ☐no

Do you have sensitive teeth?.....☐yes ☐no

Do you like your smile?.....☐yes ☐no

Women: Are you pregnant?.....☐yes ☐no

Are you taking birth control pills? .....☐yes ☐no

**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 at the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Signature: _____ Date: _____

Thank you for taking the time to fill this form out completely. It will enable us to help you more effectively.
If you have any questions at any time, please be sure to ask us. We are always happy to help.