Dr. Jack Gentry
Health History

Name: ______________________________ Preferred Name: ______________ Birth date: ____________
(first) (middle) (last)

Medical History

Are you currently under the care of a physician? Yes No
If yes, please explain: ______________________________
Physician's name & phone number: ______________________________
Are you presently taking any drugs or medications? Yes No
If yes, please list: ______________________________
____
Are you allergic to any medications? Yes No
If yes, please list: ______________________________
Are you now taking or have you ever had radiation or chemotherapy? Yes No
If yes, please explain: ______________________________
Have you been instructed to take antibiotics prior to dental appointments? Yes No
Women: Are you pregnant? Yes No If yes, when are you due? ______________

Circle if you have or have had the following:

Acid Reflux	Congenital Heart Defect	High Cholesterol	Nervous Condition
Anemia / Blood Disorder	Diabetes	HIV Positive / AIDS	Previous Endocarditis
Artificial heart valves	Drug / Alcohol dependency	High / Low Blood Pressure	Penicillin Allergy
Artificial Joints	Epilepsy / Convulsions	Heart Transplant	Prosthetic Devices
Asthma / Hay fever	Heart Murmur	Knee / Hip Replacement	Stents / Shunts
Blood transfusion	Hepatitis	Liver Disease	Thyroid Disorder
Cancer	Heart Disease	Latex Allergy	Tuberculosis

Do you have any medical conditions that we should be aware of? Yes No
If yes, please explain: ______________________________

Dental History:

Last visit to a dentist? ______________ Dentist's name: ______________ Phone #: ______________
Have you had full mouth series of x-rays (18 film) or panoramic x-ray in the last 3 yrs? Yes No
Have you had a reaction to a local anesthetic? Novocain? Yes No
Is there anything you would like to change about your smile? Yes No
If yes, please explain: ______________________________
When would you most likely start any dental treatment? (Circle one response below:)
~To bring mouth to optimal health ~When things are getting worse ~When in pain

Circle if you currently have or have had the following:

Gums bleed	Orthodontic braces	Smoking / Tobacco usage	Ear congestion
TMJ pain / noise	Dizziness	Chronic headaches	Neck / Upper back pain
Ringing in ears	Numbness of hands / fingers	Clenching/Grinding of teeth	

To the best of my knowledge, all of the proceeding answers are true and correct. If there is a change in my health, I will inform my doctor at the next appointment.

Signature: ______________________________ Date: ______________