

Medical History



Name: _____

How often do you brush your teeth? Less 1*daily 2*daily More

How often do you floss? Less 1*daily 2*daily More

How often do you drink acidic beverages such as:
Soda, juice, wine, tonic? Less 1*daily 2*daily More

How often do you eat acidic foods such as:
Citrus, oranges, grapes, apples? Less 1*daily 2*daily More

How often do you drink sugary beverages such as:
Soda, fruitdrink, juice, chocolate, coffee/tea w sugar? Less 1*daily 2*daily More

How often do you eat sugary foods such as:
Candy, cornflakes, marmelade, jam, pastry, cake? Less 1*daily 2*daily More

Do you use prescription medicine? Yes: No

If yes, please specify: _____

Do you use non-prescription medicine? Yes: No

If yes, please specify: _____

Do you use natural or alternative medicine? Yes: No

If yes, please specify: _____

Are you allergic to anything? Yes: No

If yes, please specify: _____

Have you had any disease or illness that required reference
to a specialist or hospitalization? Yes: No

If yes, please specify: _____

Are you being monitored by doctor/hospital? Yes: No

If yes, please specify: _____

Do you have any artificial parts of your body? Yes: No

If yes, please specify: _____

Are there any other health issues you can tell about? Yes: No

If yes, please specify: _____

Are you uncomfortable with going to the dentist? Yes: No

If yes, please specify: _____

Do you have specific demands in relation to treatment? Yes: No

If yes, please specify: _____

Have you been or are you in treatment for osteoporosis? Yes: No

Have you been or are you in treatment for cancer? Yes: No

Signature: _____ **Date:** _____