MEDICAL HISTORY

PATIENT NAME_____ Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Have you taken any medication for Osteoporosis?	Yes	No	If yes, please explain: _____
Have you had radiation/chemotherapy?	Yes	No	If yes, please explan: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes, please explan: _____
Do you use tobacco?	Yes	No	If yes, please explan: _____
Do you use controlled substances, legal or illegal?	Yes	No	If yes, please explan: _____
Do you need to pre-medicate before dental treatment?	Yes	No	If yes, please explan: _____

Please list all medications/vitamins or suppliments you are currently taking:_____

_____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Diabetes	Yes	No	Kidney Problems	Yes	No	Scarlet Fever	Yes	No
Anemia	Yes	No	Epilepsy or Seizures	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Artificial Heart Valve	Yes	No	High Bloode pressure	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Artificial Joint	Yes	No	Herpes	Yes	No	Liver Disease	Yes	No	Tumors or Growths	Yes	No
Blood Pressure	Yes	No	Heart Murmur	Yes	No	Mitral Valve Prolaps	Yes	No	Thyroid Disease	Yes	No
Blood Disease	Yes	No	Heart Pace Maker	Yes	No	Pain in Jaw Joints	Yes	No	Venereal Disease	Yes	No
Cancer/ Chemotherapy	Yes	No	Hepatitis A	Yes	No	Parathyroid Disease	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_____

_____

_____

Dental History

Date of last dental visit_____ Reason for leaving prior dentist? _____

Have you ever had a bad experience with a dentist? If so please explain. _____

Is there anything we can do to make your dental visit more comfortable?_____

Is there anything that bothers you about the appearance of your teeth or smile?_____

Please check all that apply:

- ☐ Bad breath
- ☐ Gums hurt/ bleeding
- ☐ Food trap
- ☐ Periodontal disease
- ☐ Jaw Popping /Clicking
- ☐ Changes in bite
- ☐ Loose teeth
- ☐ Lock Jaw
- ☐ Sores in mouth
- ☐ Sentivity to Hot/ Cold
- ☐ Sentivity to sweets
- ☐ Grinding teeth

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT/ GUARDIAN _____ DATE _____BP_____/_____

SIGNATURE OF PATIENT/ GUARDIAN _____ DATE _____BP_____/_____