MEDICAL HISTORY

PATIENT NAME ______________________________________ Birth Date__________________________________

Primary Physicain____Phone________________

Orthopedic and/or Heart Doctor____Phone________________

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? No Yes Please explain: ____

Have you ever been hospitalized or had a major operation? No Yes Please explain:____

Have you ever had a serious head or neck injury? No Yes Please explain:____

Are you taking any medications, pills, or drugs? No Yes Please list: ____

____

____

Do you take, or have you taken, Phen-Fen or Redux? No Yes

Have you taken Fosomax, Boniva, Actonel or meds with bisphosphonates? Yes No

Are you on a special diet? No Yes Please explain: ____

Do you use tobacco? No Yes Please explain:____

Do you use controlled substances? No Yes Please explain:

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

Are you allergic to any of the following?

___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics

___Sulfa Drugs ___Other:____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Do you take or have you ever taken antibiotic premedication for dental work? No Yes If yes, why and what antibiotic? ____________________

Have you ever had any serious illness not listed above? No Yes Please explain:____

____

Comments: ____

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, PARENT, or GUARDIAN ____ DATE ____________________

PATIENT DENTAL HISTORY

Previous Dentist and Location____ Date of last Exam__________

Please list problems concerns____

Do your gums bleed while brushing or flossing? __Yes __No ____

Are your teeth sensitive to hot or cold liquids/foods? __Yes __No ______________________________________

Do you feel pain in any of your teeth? __Yes __No ____

Do you have any sores or lumps in or near your mouth? __Yes __No____________________________________

Have you had any orthodontic treatment? __Yes __No When?____

Have you had any of the following problems in your jaw? __ Clicking __Pain (joint, ear, side of face)

__Difficulty in opening or closing __Difficulty in chewing OTHER:__________________________________

Do you wear dentures or partials? __Yes __No If yes, date of placement_______________________________

Do you have trouble sleeping due to snoring? __Yes __No ____

Do you have frequent headaches? __Yes __No ____

Do you bite your lips or cheeks frequently? __Yes __No ____

Have you had difficult extractions in the past? __Yes __No ____

Have you had prolonged bleeding after extractions? __Yes __No ______________________________________

Do you like your smile? __Yes __No____

Would you like for your teeth to be straighter? __Yes __No Whiter? __Yes __No

Other?________________________

THANK YOU! WELCOME TO OUR OFFICE!