

MEDICAL HISTORY

PT. NAME _____ Birthdate _____ Today's date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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. (CONFIDENTIAL)

Are you under a physician's care now? Y ___ N ___ If yes, name and Ph.# of physician _____

Have you ever had any serious illness or had a major operation? _____

Are you taking any medications, pills, or drugs? Y ___ N ___ Please list _____

Do you use any tobacco products? _____ How frequent? _____ Past use? _____

WOMEN: Are you pregnant/trying to get pregnant? Y ___ N ___ Taking oral contraceptives? Y ___ N ___

Are you allergic to, or have you ever reacted adversely to:

___ Aspirin ___ Penicillin/Amoxicillin ___ Codeine ___ Latex ___ Metal ___ Local anesthetics ___ Acrylic
___ Sulfa drugs ___ Other _____

Do you have, or have you had, any of the following? (* Condition may require premedication)

- | | | |
|--|--|---|
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Mitral Valve Prolapse* |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Rheumatic Fever* |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Scarlet Fever* |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Intestinal Disease |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> HIV positive/AIDS | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other: _____ |

Do you have any disease, condition or problem not listed above that you think that I should know about? If so, please explain _____

Dental History

Reason for visit _____

Are you having pain at this time? _____

Previous dentist and address _____

Date of last complete series of x-rays _____

Date last treated _____

What was done at that visit? _____

Date of last dental cleaning _____

Have you ever had:

Orthodontic treatment	Yes	No
Oral Surgery	Yes	No
Periodontal (gum) treatment or surgery	Yes	No
Your teeth ground or the bite adjusted	Yes	No
Had endodontic (root canal) therapy	Yes	No

Are you satisfied with the appearance of your teeth? Yes No

Are any teeth sensitive to heat, cold, chewing or sweets? Yes No

Have you noticed any loosening of your teeth? Yes No

Does food tend to become caught between your teeth? Yes No

Do you suffer from pain and/or bleeding of your gums? Yes No

Do your gums bleed often when you brush/floss your teeth? Yes No

Problems of the jaw: Have you ever experienced:

Clicking of the jaw	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening and closing	Yes	No
Difficulty in chewing and swallowing	Yes	No

Do you have any other conditions, problems, or questions about your dental health or history that you care to discuss with us? _____

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 _____ Date _____

Dentist's signature _____ Date _____