

Medical and Dental History

1. Are you currently under the care of a physician? Yes No Physician's Name: _____

Please list reasons: _____

2. Are you taking any prescription or over-the-counter drugs? Yes No

Please list each one: _____

3. Are you having any pain or discomfort at this time? Yes No If so, what? _____

4. Do you bleed excessively when you are injured? Yes No

5. *For Women:* Are you pregnant? Yes No * Are you nursing? Yes No * Are you taking Birth Control? Yes No

6. Are you taking or have you taken in the last two years any appetite suppressants, such as fen-phen? Yes No

Please list each one: _____

7. When you exercise do you ever have to stop because of pain in your chest, shortness of breath, or because you feel tired? Yes No

Please explain: _____

8. Do your ankles swell during the day? Yes No

9. Do you use more than two pillows to sleep? Yes No

10. Have you lost or gained more than ten pounds in the past year? Yes No

11. Do you ever wake up from sleep and feel short of breath? Yes No

12. Do you smoke or chew tobacco? Yes No If yes, how many packs a day? _____

13. Have you ever had any Periodontal (gum) treatment or Orthodontic corrections; for example Root Planning or Braces? Yes No

Please explain & give approximate date of completion: _____

14. Indicate which of the following you have had or have at the present time:

- | | | |
|--|--|---|
| AIDS/HIV+ <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation/Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies/Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A, B, or C <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (explain below) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | |

If you checked Heart Problem or Other, please explain: _____

15. Indicate which of the following you may or may not be allergic to:

- | | | | |
|--|---|---|---|
| Acetaminophen <input type="checkbox"/> Yes <input type="checkbox"/> No | Dental Anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Gloves <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No | Erythromycin <input type="checkbox"/> Yes <input type="checkbox"/> No | Metals (Jewelry) <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Codeine <input type="checkbox"/> Yes <input type="checkbox"/> No | Ibuprofen <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No | Other <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list any other allergies you have: _____

16. Whom should we contact in case of an emergency? Name: _____ Phone: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Signature Of Patient (Over 18 years of age) * Date: _____

Signature Of Parent Or Guardian (if patient is under 18 years of age) * Date: _____

MEDICAL HISTORY UPDATED

1. DATE: _____ REVIEWED BY DOCTOR: _____ 3. DATE: _____ REVIEWED BY DOCTOR: _____
2. DATE: _____ REVIEWED BY DOCTOR: _____ 4. DATE: _____ REVIEWED BY DOCTOR: _____