



# MEDICAL HISTORY

Medical Doctor's Name & Phone Number: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Are You Under a Doctor's Care Now?  No  Yes If Yes, Why? \_\_\_\_\_

Have You Ever Been Hospitalized?  No  Yes If Yes, When? \_\_\_\_\_

Are You Allergic To:  Penicillin  Codeine  Aspirin  Local Injected Anesthetic  Latex  Other: \_\_\_\_\_

Are You Taking Any Medications?  No  Yes If Yes, What? \_\_\_\_\_

Are You Pregnant?  No  Yes If Yes, What Week? \_\_\_\_\_

Have You Ever Been Told By Your Physician To Pre-Medicate Before Dental Visits?  No  Yes If Yes, With What Medication? \_\_\_\_\_

Do You Smoke?  No  Yes If Yes, How Much? \_\_\_\_\_ How Many Years? \_\_\_\_\_ Do you use any tobacco products? \_\_\_\_\_  
(specify)

**Please Check All That Apply:**

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> AIDS (HIV)       | <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Swelling Of Ankles/Feet | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Cortisone Medication     | <input type="checkbox"/> X-Ray/Cobalt Tx        |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Recent Weight Loss       | <input type="checkbox"/> Chemotherapy/Radiation |
| <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Fainting or Dizziness   | <input type="checkbox"/> Cold Sores       | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Arthritis/Gout         |
| <input type="checkbox"/> Heart Pacemaker         | <input type="checkbox"/> Blood Disease/Disorder  | <input type="checkbox"/> Fever Blisters   | <input type="checkbox"/> Excessive Thirst         | <input type="checkbox"/> Rheumatism             |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Lung Disease     | <input type="checkbox"/> Kidney Trouble           | <input type="checkbox"/> Artificial Joints      |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Sickle Cell Anemia      | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Thyroid Disease          | <input type="checkbox"/> Pain in Jaw Joints     |
| <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Hypoglycemia            | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Parathyroid Disease      | <input type="checkbox"/> Nervousness            |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Frequent Cough   | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Psychiatric Care       |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Hepatitis(Which kind?__) | <input type="checkbox"/> Alzheimer's Disease    |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Bruise easily           | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Yellow Jaundice          | <input type="checkbox"/> Drug Addiction         |
| <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Hay Fever        | <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> Epilepsy/Seizures      |

Do You Have Any Other Medical Conditions That May Not Be Listed Above?  No  Yes If Yes, What? \_\_\_\_\_

Reason for This Visit: \_\_\_\_\_

Name and Address of Previous Dentist: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Date Of Last Full Mouth/Panoramic X-Ray: \_\_\_\_\_ Date of Last Bitewing X-Rays: \_\_\_\_\_

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Have You Ever Had A Problem With Dental Treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Do You Wear Partials Or Dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Do Your Gums Bleed Easily?	<input type="checkbox"/>	<input type="checkbox"/>	Have You Ever Had Gum Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do You Gag Easily?	<input type="checkbox"/>	<input type="checkbox"/>	Are You Happy With The Appearance of Your Smile?	<input type="checkbox"/>	<input type="checkbox"/>
			Do You Clench Or Grind Your Teeth?	<input type="checkbox"/>	<input type="checkbox"/>

Please Add Anything Else You Feel Is Important For Us To Know: \_\_\_\_\_

Printed Name (Patient) \_\_\_\_\_ Signature (Patient or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

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