MEDICAL / DENTAL HISTORY

Patient Name ____ ***Birthdate***_______________

Emergency Contact Name____

Spouse / Parent / Other________________________________ ***Phone*** ____

Please CIRCLE any of the following which you have or have had in the past

Do you require antibiotics before dental treatment? Y N **PRE-MED DOSAGE** ____________________________

Your current physical health is: ______Excellent ______Good ______Fair ______Poor

Y N Heart Conditions (Murmur, Rheumatic heart disease, congenital defect, Mitral Valve Prolapse, Heart attack Coronary artery disease, irregular heart beat, Congestive heart failure) or other

Y N Chest Pain (Angina)

Y N Heart Procedures – Stents, catheterization, Angioplasty, Pacemaker, Bypass surgery, Prosthetic valve placement Date of surgery _______________

Y N Stroke / TIA's

Y N High Blood Pressure

Y N Blood Transfusions- Date ______________________

Y N Blood disorders (anemia, bleeding tendencies, etc)

Y N Stomach or Intestinal disease (GERD, Ulcers, colitis, Diverticulitis, Hernia, Hiatal hernia)

Y N Diabetes (or family history of)

Y N Cancer, Tumors, or Growths (include skin, benign etc)
____

Y N Radiation therapy (X-ray treatments for Cancer)

Y N Fainting spells / Vertigo

Y N Frequent Headaches or earaches

Y N TMJ (Jaw joint) problems or limited opening of mouth

Y N Organ Transplants ___________________________

Y N Kidney Disease / Stones

Y N Autoimmune disease such as lupus, pemphigus, pemphigoid, lichen planus

Y N Pregnant or breast-feeding currently (Women only)

Y N Are you past Menopause (Women only)

Y N Glaucoma

Y N Thyroid Disease

Y N Liver Disease (Cirrhosis, Hepatitis, Etc)

Y N Respiratory (Lung) Disease (Emphysema, Asthma, COPD, Tuberculosis, etc)

Y N Cortisone or steroid type medications

Y N Prosthetic Joints or valves (Hip replacements, etc) Type/Date___________________________________

Y N Seizure Disorder (Epilepsy, traumatic)

Y N Arthritis (Rheumatoid, Osteo, Fibromyalgia, gout)

Y N Allergies (hay fever, foods, materials, or medications)
____

Y N Sinus Problems

Y N Loss of Weight (without dieting)

Y N History of Surgery, especially several repeated Procedures in childhood

Y N Are you allergic to or unable to eat bananas, kiwis, avocados, chestnuts, tomatoes, potatoes, or hazelnuts?

Y N Do you have a heavy persistent cough of 2-3 weeks duration, particularly one that brings up sputum or bloodied sputum?

Y N Infectious disease (AIDS, Herpes, Syphilis, Tuberculosis, Hepatitis A, B, or C or other)

Y N Substance abuse (alcohol, cocaine, drugs, etc)

Y N Other ______________________________________

Y N Have you ever had a root canal before? If so, how would you rate your last root canal experience?
____

Y N Is there anything we can do to make you more comfortable during your visit in our office today?
____
____

STAFF ONLY: DATE _____/_____/_____	DATE ______/______/______	DATE ______/______/______
BP:______/______ PULSE: _____________	BP:_______/_______ PULSE:__________	BP:______/______ PULSE:________
STAFF INIT: ___________	STAFF INIT: _____________	STAFF INIT:____________

OVER ➔

MEDICAL / DENTAL HISTORY

*PATIENT NAME*________________________________

Please list all physicians and their specialty:

Family Physician: ____________________________
Phone: ____________________________________
Address: ___________________________________
Date of Last Visit: ___________________________

Physician: ________________________________
Specialty: ________________________________
Phone: ___________________________________
Address: __________________________________
Date of Last Visit: ___________________________

Physician: ________________________________
Specialty: ________________________________
Phone: ____________________________________
Address: ___________________________________
Date of Last Visit: ___________________________

Physician: ________________________________
Specialty: ________________________________
Phone: ___________________________________
Address: __________________________________
Date of Last Visit: ___________________________

Please list any current medications you are taking and reason. Include prescription, supplements, and over-the-counter.

Name of Medication	Dosage	Reason

Have you experienced an allergic or unusual reaction to any of the following?

____ Aspirin
____Sulfa drugs
____Penicillin
____Erythromycin
____Tetracycline
____Barbiturates
____Pain medication
____Acetaminophen
____Ibuprophen
____Latex
____Local anesthetic (Novocain)
____Codeine

Please list any other drugs or materials that you are allergic to: ____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature Date