MEDICAL and DENTAL HISTORY

Welcome to our office. To assist us in serving you, please complete the following confidential form.

Patient's name ____ Birth date _______________________

Medical Health History

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer – Type and Status _______________________
- ❑ Heart murmur or defect – Type_____________________
- ❑ Heart attack or angina
- ❑ Heart surgery
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pacemaker
- ❑ Emphysema or difficulty breathing
- ❑ Kidney disease
- ❑ Hepatitis (A B C) or other liver disease – Type _________
- ❑ Alcoholism / Addiction
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition – Type_______________________
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition – Type _______________________
- ❑ Arthritis
- ❑ Cold sores or Oral Herpes
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders – Type _________________
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever, sinus trouble or allergies
- ❑ Thyroid Problem – Type________________________
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____________________________________

Please list the medications you are taking:

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners) _________________
- ❑ Antibiotics or sulfa drugs ______________________
- ❑ High blood pressure medicine __________________
- ❑ Antidepressants or tranquilizers ________________
- ❑ Insulin, Orinase, or other diabetes drug ___________
- ❑ Nitroglycerin _______________________________
- ❑ Cortisone or other steroids ____________________
- ❑ Osteoporosis (bone density) medicine ____________
- ❑ Other:_____________________________________
  ____

Women:

- ❑ May be pregnant
  Expected delivery date: ____________
- ❑ Taking hormones or contraceptives YES NO

Have you ever been informed that you need to take premedication prior to dental treatment? ❑ yes ❑ no

Name of your physician:____

Do you have any disease, condition, or problem not listed above?_____________________________________

Please add anything else you would like us to know about: ____

Why have you come to the dentist today? ____

Previous Dentist Name, City and State: ____

When was your last dental visit? ____

Are your teeth sensitive to: o HOT o COLD o SWEETS o PRESSURE

What condition do you feel your mouth is in? oPOOR o FAIR o GOOD o EXCELLENT

What condition do you want your mouth to be in? oPOOR o FAIR o GOOD o EXCELLENT

Do you ever have pain or popping noises in your jaw joints? YES NO

Do you grind or clench your teeth at night? YES NO

Are you interested in whitening your teeth? YES NO

Have you ever been told that you have periodontal disease? YES NO

Have you ever been told that you need crowns or bridgework? YES NO

Are you currently having pain or discomfort? YES NO

Are you nervous about dental treatment? YES NO

Have you had a bad experience at a dental office? YES NO

All preceding answers are true and correct to the best of my knowledge. If there are any changes in my health, or if my medications change, I will inform the doctor at my next appointment.

Signature of patient (or guardian) ____________________________________ Date ________________