Medical History

Patients Name_____

1. When was your last physical examination? _____ Physician _____ Phone _____
2. Are you being treated by a physician? Yes No If yes, please explain _____
_____
3. Has there been any change in your health in the last year? Yes No If yes, please explain _____
_____
4. Have you experienced any illness, accident, surgery or hospitalization in the past 5 years? If yes when and where? _____
_____
5. Have you ever has a serious head and neck injury? Yes No If yes, Explain _____
_____
6. Do you use tobacco (smoke, chew), Marijuana, or drink alcohol daily? (Specify) _____
7. Do you use controlled substances? Yes No (Specify) _____
8. Are you or have you taken in the past **osteoporosis medications** (Fosamax, Actonel, Boniva, Reclast, Other)? Yes No
_____
9. Woman:
   Pregnant / trying to get pregnant? Yes No If Pregnant, how many weeks into your pregnancy? _____
   Taking contraceptives? Yes No If Yes, the name of the contraceptive _____
   Nursing? Yes No
10. DO YOU NEED **PREMED** BEFORE DENTAL APPTS? Yes No If Yes, for what condition? _____
_____
11. Are you **allergic to** any of the following: Yes No
    Latex Penicillin Aspirin Codeine Local Anesthetics (Novocain) Metal Acrylic
    List all of the other medications or drugs you are **allergic to**: None _____
_____
12. Do you have any unusual reaction to dental injections? Yes No If yes, explain _____
_____
13. **List medications** (include Aspirin, over the counter medications and substitutes) you are currently taking and their dosages if you know: None _____
_____
_____

14. *Do* you have or *have you had* any of the following:

Condition	Yes	No	Condition	Yes	No
Heart Trouble/Pacemaker			Anemia/blood problems/severe bleeding		
Heart Attack			Blood transfusion		
Heart Murmur			High Cholesterol		
Chest Pain			Cancer		
Stroke			Tumors or growths		
Prosthetic joint replacement			Chemotherapy		
Rheumatic Fever			Immunosuppressive therapy		
AIDS, HIV (or been tested for)			Severe Infections		
Hepatitis A, B, C(or been tested for)			Pneumonia		
High or low blood pressure			Arthritis		
Tuberculosis			Seasonal Allergy, Asthma, Hay Fever		
Herpes or cold sores/Shingles			Headaches or ear aches		
Sexually transmitted disease			Back, neck or shoulder pain		
Kidney problems			Sinus or eye problems (Glaucoma)		
Dialysis			Fainting		
Diabetes, Type I or Type II			Epilepsy (Seizures)		
Liver Disease			Forgetfulness (Alzheimer's Disease)		
Thyroid problems			Depression/ADHD/ADD		
Gastro-intestinal problems (Acid reflux or Ulcer)			Psychiatric treatment		

15. Have you ever had any serious illness not listed above? Yes No If Yes, please specify _____
_____
16. Do you have dental pain or sensitivity today? Yes No If Yes, please specify _____
_____
17. Does your gum bleed when you are brushing or flossing your teeth? Yes No If Yes, specify _____
18. Do you have any cosmetic dental concerns? Whitening, Straightening, Reshaping, Other _____
19. Any comment or suggestion? _____
_____

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 of Patient (Parent or Guardian if Minor) _____ **Date** _____

Signature of Doctor or Hygienist_____ **BP: / Pulse:**

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