

MEDICAL HISTORY

Name _____ Birth Date _____

Pharmacy _____ Pharmacy Phone Number _____

Although dental professionals primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Who is your physician? _____

Are you under a physician's care right now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major surgery? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, how much per day? _____

Do you use controlled substances? Yes No If yes, please explain: _____

Are you taking any medications, pills or drugs? Yes No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin/Antibiotic Codeine Acrylic Metal Latex Other If yes, please explain:

Do you have, or have you had, any of the following? Please check all that apply.

- AIDS/HIV Positive Convulsion Heart Murmur Pacemaker
 Anemia Dementia Heart Pace Maker Pain in Jaws
 Angina Diabetes Heart Trouble/Disease Psychiatric Care
 Arthritis/Gout Drug Addiction Hemophilia Radiation Treatments
 Artificial Heart Valve Easily Winded Hepatitis Renal Dialysis
 Artificial Joint Emphysema Herpes Rheumatic Fever
 Asthma Epilepsy or Seizures High Blood Pressure Rheumatism
 Blood Disease Excessive Bleeding Hypoglycemia Sinus Trouble
 Blood Transfusion Daytime Sleepiness Irregular Heart Beat Snoring/Sleep Apnea
 Breathing Problem/COPD Fainting/Dizziness/Vertigo Kidney Problems Stomach/Intestinal Disease
 Bruise Easily Fragmented Light Sleep Leukemia Stroke
 Cancer Frequent Diarrhea Liver Disease Thyroid Disease
 Chemotherapy Frequent Headaches Low Blood Pressure Tuberculosis
 Chest Pains GERD Night Sweats Tumors or Growths
 Cold Sores/Fever Blisters Glaucoma Mitral Valve Prolapse Venereal Disease
 Congenital Heart Disorder Heart Attack/Failure Morning Headaches Yellow Jaundice

If you have had a serious illness not listed above, please explain:

- Are you happy with the appearance of your teeth? Yes No
Do your teeth hurt when you brush your teeth? Yes No
Is any part of your mouth sensitive to irritants (hot, cold, sweets)? Yes No
Does any part of your mouth hurt when clenched? Yes No
Do you have pain in your jaws, face or mouth? Yes No
Do your gums bleed when you brush or floss your teeth? Yes No
Do you have any unhealed injuries or inflamed areas in your mouth? Yes No
Do you have frequent "bad tastes" in your mouth? Yes No
Have you had prolonged bleeding after a dental extraction? Yes No
Have you ever had a TMJ disorder? Yes No
Do you clench or grind your teeth during any part of the day or night? Yes No

If you have a dental problem not listed above, please explain:

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the dental office of changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____