MEDICAL & DENTAL HISTORY

Patient Name ______________________ Date of Birth: ______________________

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

I have come to the dentist today because:

Are you currently in pain? ❍Y ❍N
Have you ever had a serious or difficult problem associated with any previous dental work? ❍Y ❍N
Discomfort in your jaw joint (TMJ I TMD)? ❍Y ❍N
Your assessment of your current health is: *Good* *Fair* *Poor*
How many times a week do you floss? __________
How many times a day do you brush? __________
Do your gums ever bleed? ❍Y ❍N
Have you ever had periodontal (gum) treatment? ❍Y ❍N
Type of tooth brush? *Rotary* *Hard* *Medium* *Soft*

Are you currently under a physician's care? ❍Y ❍N
Have you been hospitalized or had a major operation? ❍Y ❍N
Have you ever had a serious head or neck injury? ❍Y ❍N
Are you on a special diet? ❍Y ❍N
Do you use controlled substances? ❍Y ❍N
Do you smoke or use tobacco? ❍Y ❍N
Do you take or have you taken medication for bone loss:
Bisphosphonate Derivative (Fosomax, Boniva) ❍Y ❍N
Women: *Are you pregnant?* ❍Y ❍N
Taking Oral Contraceptives? ❍Y ❍N
Nursing? ❍Y ❍N

Please explain any "YES" answers: ______________________________

List all current medications: ______________________________

Previous / Present Dentist: ______________________ **Last visit date** ____________

Previous / Present Physician: ______________________ **Last visit date** ____________

Are you allergic to any of the following?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics ❍ Sulfa Drugs

Other allergies: ______________________________

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

AIDS/HIV
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Pressure: High/Low
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cholesterol
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting / Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Lung Disease
Mitral Value Prolapse
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatment
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Sleep Apnea/Snoring
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

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.

______________________________ ______________________
Patient, Parent, or Guardian Signature **Date**