MEDICAL DENTAL HISTORY

DATE OF BIRTH _____ AGE _____ DATE OF LAST HEALTH CARE EXAMINATION _____

FOR WHAT _____

HAVE YOU BEEN HOSPITALIZED IN LAST 5 YEARS? _____ IF SO, FOR WHAT? _____

_____

NAME OF YOUR PHYSICIAN _____

ARE YOU RECEIVING OTHER HEALTH CARE NOW _____. IF SO, NATURE OF CARE _____

DO YOU HAVE OR HAVE YOU EVER HAD:

TOBACCO USE: SMOKER _____ HOW OFTEN? _____
SNUFF/DIP _____ HOW LONG? _____

	YES	NO		YES	NO		YES	NO	
1.	☐	☐	LIVER DISEASE/HEPATITIS A, B, C	16. ☐	☐	ANY HEART PROBLEM	☐	☐	ALLERGIES OR SENSITIVITIES (such as nausea)
2.	☐	☐	DIABETES	17. ☐	☐	THYROID DISORDER			☐ PENICILLIN ☐ ASPIRIN
3.	☐	☐	EPILEPSY	18. ☐	☐	RINGING IN EARS			☐ ERYTHROMYCIN ☐ LOCAL ANESTHETIC
4.	☐	☐	RHEUMATIC FEVER/SCARLET FEVER	19. ☐	☐	A BLOOD PRESSURE PROBLEM			☐ CODEINE ☐ OTHER (TALC, POLLEN)
5.	☐	☐	TUBERCULOSIS	20. ☐	☐	CANCER or TUMORS			ALLERGIC TO
6.	☐	☐	ASTHMA	21. ☐	☐	WOMEN: ARE YOU PREGNANT?			☐ LATEX ☐ JEWELRY
7.	☐	☐	LUNG DISEASE	22. ☐	☐	CHRONIC SINUSITIS			DO YOU NOW HAVE (CHECK IF YES)
8.	☐	☐	HEART ATTACK/STROKE	23. ☐	☐	HEAD & NECK PAIN			☐ TOOTHACHE
9.	☐	☐	GLAUCOMA	24. ☐	☐	JAUNDICE			☐ ARTIFICIAL JOINTS OR LIMBS
10.	☐	☐	PROLONGED BLEEDING	25. ☐	☐	MITRAL VALVE PROLAPSE/HEART MURMUR			☐ BROKEN FILLINGS
11.	☐	☐	RADIATION TREATMENT	26. ☐	☐	V.D./SYPHILLIS			☐ FREQUENT HEADACHES
12.	☐	☐	ANEMIA	27. ☐	☐	KIDNEY DISEASE			☐ PROSTHETIC HEART VALVES
13.	☐	☐	ARTHRITIS	28. ☐	☐	PSYCHIATRIC TREATMENT			☐ A DRUG ABUSE PROBLEM
14.	☐	☐	AIDS or HIV POSITIVE	29. ☐	☐	TAKEN PHEN-FEN			☐ AN ULCER
15.	☐	☐	HERPES VIRUS-COLD SORES	30. ☐	☐	FAINTING OR DIZZY SPELLS, INCL. UNFAVORABLE REACTION TO DENTAL TREATMENT			

IF ALLERGIES TO MEDICATIONS OR DRUGS, INDICATE WHICH ONES _____

ARE YOU TAKING ANY MEDICATION? _____ IF SO, WHAT? _____

OTHER PHYSICAL CONDITIONS: _____

MEDICAL UPDATE:

CONDITION	DATE	MEDICATIONS	DOSAGE	DATE OF CHANGE

NAME OF FORMER DENTIST _____ PHONE NO. _____

ADDRESS _____

YES	NO		YES	NO	
___	___	HAVE YOU MADE REGULAR VISITS TO THIS DENTIST	___	___	DOES FOOD GET CAUGHT BETWEEN YOUR TEETH OFTEN
		HOW LONG SINCE LAST VISIT _____	___	___	ARE ANY TEETH SENSITIVE NOW
___	___	HAVE YOU LOST ANY TEETH	___	___	DO YOUR GUMS BLEED WHEN BRUSHING OFTEN
___	___	HAVE THEY BEEN REPLACED	___	___	DO YOU USE DENTAL FLOSS? HOW OFTEN ___X/WEEK
		WHEN _____ HOW _____	___	___	IS YOUR BREATH OFFENSIVE FREQUENTLY
___	___	DO YOU CLENCH OR GRIND YOUR TEETH	___	___	DO YOU LIKE THE APPEARANCE OF YOUR TEETH
___	___	DOES YOUR JAW CLICK OR POP	___	___	DO YOU HAVE ANY QUESTIONS OR CONCERNS:

I certify that the above information is complete and accurate.

_____ _____

PATIENT'S SIGNATURE (PARENT IF MINOR) DATE