Medical and Dental History

Patient Name_____ Date of Birth_____

Please fill out the form completely to the best of your ability. Health problems that you may have, or medication(s) that you may be taking may have an important interrelationship with the dental care you receive. Thank you.

Name of **Primary care physician** _____ Phone: (____)_____-_____
(First and last name, please)
Address/Location of Primary care Physician:_____
List any prior **Hospitalizations or surgeries** including the year and reason for hospitalization or surgery:
_____
_____
Have you ever had a serious head or neck injury? If yes, explain:_____
Please list any **medication(s)** you are currently taking, including dosage and frequency:
_____
_____
Do you take, or have you taken Phen-Fen, Redux, Bonivia, Fosamax, Actonel, Didronel, Shelid, Aredia, Zometa? (please circle)
Are you on a **special diet**? If yes, explain:_____
Do you use **tobacco**? If yes, how much and how often?_____ Smoke or smokeless (please circle)
Do you use **controlled substances**? If yes, please name and include the dosage and frequency:_____
Have you ever had **prolonged or unusual bleeding**? If yes, explain:_____

Women Only: Are you □ Pregnant/Trying to get pregnant? □ Nursing? □ Taking Oral Contraceptives?

Are you **allergic** to any of the following? □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics
□ Other: _____ Please explain the reaction _____

Do you have, or have you had, any of the following?

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

Have you ever had a **serious illness** not listed above? If yes, please explain: _____
Have you ever had a **reaction to local anesthetic**? If yes, please explain: _____
Have you ever had **complications or illness following dental treatment**? If yes, please explain: _____
Are you **currently in any pain**? If yes, please explain: _____
When was your last dental checkup? _____ Last dental cleaning? _____ X-Rays? _____
What is the name of your previous Dentist? _____Address/Location: _____
Have you ever been treated for **Active Periodontal Disease**? If yes, how long ago? _____
How often do you brush? _____ How often do you floss? _____
If you could change anything at all about your smile, what would it be? _____
_____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. If I ever have any change in my health condition or the medications I take, I will inform the Doctor on my next appointment.

Signature of Patient, Parent, or Guardian: _____ *Date:* _____