

MEDICAL HISTORY

1. Are you having any dental problems at this time? Yes No
2. Do your gums bleed at any time? Yes No
3. Do you feel nervous about having dental treatment? Yes No
4. Have you ever had a bad experience in the dental office? Yes No
5. Have you been under medical care or hospitalized during the past two years? Yes No
If yes, for what reason? _____
6. Are you allergic to any drugs or medication (itching, rash, swelling)? Yes No
7. Have you ever been made sick by penicillin, aspirin, codeine or any drugs? Yes No
8. Have you ever had any excessive bleeding requiring special treatment? Yes No
9. Women: Are you pregnant? If yes, when are you due? Yes No
Are you taking birth control pills? Yes No
10. Check any of the following which you have had or have at the present:
- | | | | |
|---|--|--|--|
| <input type="radio"/> Heart Disease or Attack | <input type="radio"/> Artificial Joint | <input type="radio"/> Thyroid Disease | <input type="radio"/> Liver Disease |
| <input type="radio"/> Angina (chest pain) | <input type="radio"/> Anemia | <input type="radio"/> Radiation therapy | <input type="radio"/> Yellow Jaundice |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Ulcers | <input type="radio"/> Chemotherapy | <input type="radio"/> Blood Transfusion |
| <input type="radio"/> Heart Murmur | <input type="radio"/> Shortness of Breath | <input type="radio"/> Glaucoma | <input type="radio"/> Diabetes |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> Emphysema | <input type="radio"/> Arthritis | <input type="radio"/> Hemophilia |
| <input type="radio"/> Congenital Heart Problems | <input type="radio"/> Tuberculosis (TB) | <input type="radio"/> Rheumatism | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Stroke | <input type="radio"/> Asthma | <input type="radio"/> Cortisone Medication | <input type="radio"/> Epilepsy or Seizures |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Sinus Trouble | <input type="radio"/> HIV Positive | <input type="radio"/> Fainting or Dizzy Spells |
| <input type="radio"/> Heart Pacemaker | <input type="radio"/> Allergies or Hives | <input type="radio"/> Hepatitis A (Infectious) | <input type="radio"/> Psychiatric Treatment |
| <input type="radio"/> Heart Surgery | <input type="radio"/> Pain in the Jaw Joints | <input type="radio"/> Hepatitis B (Serum) | <input type="radio"/> Kidney Trouble |
11. Have you been using recreational drugs? Yes No
12. Do you ever have chest pain or shortness of breath from walking? Yes No
13. Has your physician ever said you have cancer or a tumor? Yes No
14. Are you on a special diet under a physicians care? Yes No
If yes, have you taken Phen-Phen? Yes No
15. Please list any disease or condition not covered above. _____
16. If you smoke or drink, how much each day? _____
17. Please list all the medications you are taking at this time (including fluoride). _____

19. How do you feel about the appearance of your teeth? _____
20. If you could change anything about your smile, what would you change? _____

To the best of my knowledge, I have answered every question completely and accurately.

I will inform my dentist of any change in my health and/or medication.

Patient Signature _____ Date _____

History Reviewed _____ Date _____ History Reviewed _____ Date _____

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