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PATIENT MEDICAL HISTORY FORM

Your comfort and good dental health are dependent upon an accurate knowledge of your medical health. Many medical situations can affect, or be affected by, procedures or drugs used in dentistry. Therefore, please complete the following carefully:

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (PLEASE CIRCLE)

Heart Disease	Heart Murmmer	Bruise Easily	Asthma/Hay Fever	Liver Disease	Fainting/Dizziness	Drug Addiction	Unexplained weight gain/loss	Total Joint Replacement
Angina Pectoris	Congenital Heart Disease	Prolonged Bleeding	Emphysema	Jaundice (other than birth)	HIV +	Psychiatric Treatment	Tonsilitis	Osteoporosis
Chest Pains	Rheumatic Fever	Anemia	Tuberculosis (TB)	Hepatitis	AIDS	Cancer	Chronic Sinus Problems	Fosamax use
High Blood Pressure	Stroke	Blood Transfusion	Diabetes	Thyroid Disease	Cold Sores	Radiation Therapy	Low Blood Pressure	Dry Mouth
Shortness of breath	Hemophilia	Sickle Cell Disease	Ulcers	Glaucoma	Genital Herpes	Chemotherapy	Coumadin (Wafarin) use	Halitosis (Bad Breath)
Swollen Ankles	Artificial Heart Valve	Arthritis	Kidney Trouble	Seizures	Venereal Disease	Implant Prosthesis	Blood Thinners	Staph Infection

PLEASE ANSWER EACH QUESTION AS DETAILED AS POSSIBLE:

1. DO YOU CURRENTLY HAVE ANY SERIOUS MEDICAL CONDITIONS, FOR WHICH YOU ARE BEING TREATED?____________________
____
____

2. ARE YOU ALLERGIC TO ANY MEDICATIONS OR MATERIALS (INCLUDING LATEX, PENICILLIN, CODEINE, ASPIRIN, LIDOCAINE, NOVACAINE)?____________
____

3. HAVE YOU EXPERIENCED ANY COMPLICATIONS FOLLOWING A DENTAL TREATMENT?____________________
____

4. DO YOU HAVE ANY DISEASES NOT CIRCLED ABOVE?____________________

5. HAVE YOU BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?____________________

6. HAVE YOU BEEN TOLD TO TAKE ANTIBIOTICS PRIOR TO DENTAL CARE?____________________

7. PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING. IF YOU HAVE A COPY OF YOUR LIST OF MEDICATIONS, PLEASE ALLOW US TO COPY IT FOR YOUR FILE:____________________
____
____

8. (WOMEN ONLY, PLEASE CIRCLE)
   1. ARE YOU PREGNANT? YES NO IF YES, WHAT TRIMESTER: 1ST 2ND 3RD
   2. ARE YOU TAKING HORMONE MEDICATIONS? YES NO
   3. ARE YOU TAKING BIRTH CONTROL PILLS? YES NO
   4. ARE YOU TAKING FERTILITY MEDICATIONS? YES NO

9. HOW LONG HAS IT BEEN SINCE YOUR LAST DENTAL EXAM AND CLEANING?____________________

10. DO YOU HAVE ANY FEAR OF THE DENTIST?___________IF YES, (PLEASE CIRCLE) MILD MODERATE SEVERE

11. DO YOU HAVE ANY DENTAL PAIN RIGHT NOW?_______IF YES, (PLEASE CIRCLE) **NO PAIN 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN**
    PLEASE DESCRIBE THE PAIN (CIRCLE): THROBBING HOT/COLD SENSITIVITY PRESSURE SWELLING/LUMP ULCER CHEWING PAIN
    WHEN DID THE PAIN FIRST BEGAN?____________________ IS THE PAIN GETTING WORSE?__________ IS THE PAIN CONSTANT?__________ SPONTANEOUS?_________

12. HOW OFTEN DO YOU BRUSH YOUR TEETH? (PLEASE CIRCLE) NOT DAILY DAILY >2X DAILY FLOSS? (PLEASE CIRCLE) NOT DAILY DAILY >2X DAILY

13. DO YOU USE ANY TOBACCO PRODUCT?___________IF YES, (PLEASE CIRCLE) SMOKELESS CIGARS CIGARETTES HOW OFTEN PER DAY?__________________

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT:

NAME (PRINT):____________________ DATE____________________

SIGNATURE:____________________