

MEDICAL HISTORY

Name _____

Circle any of the following which you have had or have at present:

Heart Murmur	Arthritis	Sickle Cell Anemia	Heart Disease or Attack
Stroke	Rheumatism	Thyroid Disease	Congenital Heart Lesions
Angina Pectoris	Kidney Trouble	Diabetes	High Blood Pressure
Heart Failure	Scarlet Fever	Substance Abuse	Epilepsy or Seizures
Heart Pacemaker	Rheumatic Fever	Alcoholism	Artificial Joint
Heart Surgery	Bruise Easily	Tuberculosis (TB)	Sexually Transmitted Disease
Asthma	Cold Sores	Ulcers	Artificial Heart Valve
Emphysema / COPD	Hemophilia	Sinus Troubles	X-ray or Cobalt Treatment
Anemia	Hepatitis	Glaucoma	Chemotherapy
Liver Disease	HIV Positive	Allergies or Hives	Fainting or Dizzy Spells
Yellow Jaundice	Blood Transfusion	Pain in Jaw Joints	Cortisone Medicine
Major Surgeries	Cancers or Tumors	Psychiatric / Mood disorders	Latex Allergy

Is there another medical condition not listed above of which we need to be aware? _____

Physician's Name _____ Address _____ Phone: _____

Have you seen a medical doctor during the past two years? _____

Are you currently taking any medicine? _____

If so, please list: _____

Have you been warned against taking a specific medicine? _____

Are you allergic to or made sick by penicillin, aspirin, codeine or any other drugs or medication? _____

Have you ever had any excessive bleeding requiring special treatment? _____

When you walk up stairs or take a walk, do you ever have to stop because of

Pain in your chest, shortness or breath, or because you are very tired: _____

Do you use tobacco in any form? _____ What form do you use? _____ How often? _____

WOMEN: Are you pregnant? _____ If so, how many months? _____

DENTAL HISTORY

Former Dentist: _____ Address: _____ Phone: _____

How long has it been since your last dental visit? _____ Were X-rays taken? _____

Is there anything specific you would like us to do regarding your teeth or gums? _____

Are you nervous about going to the dentist? _____

What can we do to make your dental visit more pleasant? _____

Would you like to know more about sedation techniques? _____

Are you having dental pain? _____ If so, where? _____

Do you currently have any of the following?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Decayed Teeth | <input type="checkbox"/> Broken/Rough Fillings | <input type="checkbox"/> Jaw or Joint Pain | <input type="checkbox"/> Clicking/Popping Jaw Joint |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Food Catches Between Teeth |

Are your teeth sensitive to:

- Sweets Hot Cold Biting Pressure Where? _____

Do you use dental floss? _____ How often? _____

Are you happy with the appearance of your teeth? _____ What would you change if you could? _____

Certification: I hereby certify that the answers to this history are accurate to the best of my knowledge.

Signature of Patient (or parent if Minor)

Date

Reviewed by _____ Date _____ B/P _____ P _____ ASA I II III IV

