Medical / Dental History

Patient Name _____ DOB _____ Date_____

Patient Medical History- *please check **YES** or **NO***

Y/N

□ □ Are you under medical treatment now?
□ □ Are you on a diet at this time?
□ □ Do you smoke?
□ □ Do you have any reason you are not in good health?
□ □ Have any wounds healed slowly or presented complications?
□ □ Are you pregnant? If so weeks _____
□ □ Are you Allergic to any medications? If **YES** specify_____
□ □ Are you taking any drugs or medications? If **YES** specify
_____
□ □ Are you now or have ever taken a bisphosphonate drugs for osteoporosis? If YES which_____ how long ago? _____

Y/N <u>Have you ever had, or have any of the following:</u>

□ □ Abnormal Bleeding
□ □ Alcohol Abuse
□ □ Allergies
□ □ Anemia
□ □ Angina Pectoris
□ □ Arthritis
□ □ Artificial Heart Valve
□ □ Asthma
□ □ Blood Transfusion
□ □ Cancer – Chemotherapy
□ □ Colitis
□ □ Congenital Heart Defect
□ □ Cosmetic Surgery
□ □ Diabetes
□ □ Difficulty Breathing
□ □ Drug Abuse
□ □ Emphysema
□ □ Fainting Spells
□ □ Fever Blisters
□ □ Frequent Headaches
□ □ Glaucoma
□ □ Hay Fever
□ □ Heart Attack
□ □ Heart Murmur
□ □ Heart Surgery
□ □ Hemophilia
□ □ Hepatitis If **YES** specify A / B / C
□ □ High Blood Pressure
□ □ HIV / AIDS **Date Tested** _____
□ □ Joint Replacements **When _____**
□ □ Kidney Problems
□ □ Leukemia
□ □ Liver Disease
□ □ Low Blood Pressure
□ □ Mitral Valve Prolapse
□ □ Pace Maker
□ □ Pneumonia
□ □ Psychiatric Problems
□ □ Radiation Therapy
□ □ Rheumatic Fever
□ □ Seizures
□ □ Shingles
□ □ Sickle Cell Disease
□ □ Sinus Problems
□ □ Stroke
□ □ Thyroid Problems
□ □ Tuberculosis
□ □ Tumors / Growths
□ □ Ulcers
□ □ Venereal Disease
□ □ Yellow Jaundice

Patient Dental History- *please check **YES** or **NO***

Y/N

□ □ Do you have any specific problems? If **YES** specify_____
□ □ Do you have pain in or around your ears?
□ □ Do you have any unhealed injuries or inflamed areas in or around your mouth?
□ □ Have you experienced growth or sore spots in your mouth?
□ □ Does any part of your mouth hurt when clenched?
□ □ Do you have any reactions to Novocain or any other Dental Anesthetic?
□ □ Have you ever had difficult extractions in the past?
□ □ Have you ever had prolonged bleeding following an extraction?
□ □ Do your gums bleed?
□ □ Have you ever been instructed on the correct method of brushing and flossing your teeth?
□ □ Do you only chew on one side of your mouth?
□ □ Do you habitually clench or grind your teeth during the day or night?
□ □ Any part of your mouth sore to pressure, hot/cold, sweet? If **YES** where_____

When was your last full mouth x-ray taken? _____ Where _____

If you could change anything about your smile what would it be?
_____

I certify that the answers given are correct to the best of my knowledge, and I will keep the office informed of any changes regarding my medical history.

Patient Name _____ Signature _____Date_____

If minor Parent / Guardian name _____ Signature _____ Date _____