

PATIENT NAME _____ DATE _____

DENTAL HISTORY

NAME OF PREVIOUS DENTIST _____

LAST REGULAR DENTAL APPOINTMENT _____ DATE OF LAST FULL MOUTH X-RAYS _____

HAVE YOU EVER HAD COMPLICATIONS RELATED TO DENTAL TREATMENT? EXPLAIN _____

MEDICAL HISTORY

ARE YOU UNDER A PHYSICIAN'S CARE NOW? WHY? _____

HAVE YOU EVER BEEN HOSPITALIZED, HAD A MAJOR OPERATION, OR SIGNIFICANT TRAUMATIC INJURY? EXPLAIN _____

PLEASE LIST ANY MEDICATIONS, PILLS, DRUGS OR HERBAL SUPPLEMENTS YOU ARE TAKING _____

DO YOU HAVE ANY MEDICAL CONDITIONS NOT LISTED BELOW? _____

DO YOU HAVE ANY DISABILITY WHICH MAY AFFECT OUR ABILITY TO TREAT YOU, OR YOUR ABILITY TO CARE FOR YOUR TEETH? EXPLAIN _____

ARE YOU ON A SPECIAL DIET? EXPLAIN _____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? PLEASE CIRCLE BELOW:
ASPIRIN PENICILLIN CODEINE ACRYLIC METAL LATEX RUBBER OTHER _____

WOMEN (please circle) PREGNANT/TRYING TO GET PREGNANT NURSING TAKING ORAL CONTRACEPTIVES

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE THOSE THAT APPLY

- | | | | | |
|---------------------------|--------------------------|---------------------|----------------------|-----------------------|
| HEART DISEASE | HIGH BLOOD PRESSURE | SHORTNESS OF BREATH | ULCERS | THYROID DISEASE |
| HEART MURMUR | LOW BLOOD PRESSURE | FREQUENT COUGH | RECENT WEIGHT LOSS | PARATHYROID DISEASE |
| IRREGULAR HEART BEAT | BLOOD DISEASE | HAY FEVER | STROKE | ARTHRITIS/GOUT |
| ANGINA/CHEST PAIN | BRUISE EASILY | SINUS TROUBLE | DIABETES | PAIN IN JAWS |
| HEART ATTACK/FAILURE | ANEMIA | ASTHMA | EXCESSIVE THIRST | ARTIFICIAL JOINT |
| CONGENITAL HEART DISORDER | EXCESSIVE BLEEDING | ALLERGIES | HYPOGLYCEMIA | VENEREAL DISEASE |
| MITRAL VALVE PROLAPSE | SICKLE CELL DISEASE | EMPHYSEMA | LIVER DISEASE | AIDS/HIV POSITIVE |
| SCARLET FEVER | HEMOPHILIA | TUBERCULOSIS | HEPATITIS A, B, C | PSYCHIATRIC CARE |
| RHEUMATIC FEVER | LEUKEMIA | CANCER | TUMORS/GROWTHS | DRUG ADDICTION |
| ARTIFICIAL HEART VALVE | RECENT BLOOD TRANSFUSION | RADIATION TREATMENT | ALZHEIMER'S DISEASE | HERPES/COLD SORES |
| HEART PACEMAKER | SWELLING OF LIMBS | CHEMOTHERAPY | EPILEPSY or SEIZURES | HIVES/RASH |
| HEART SURGERY | LUNG DISEASE | STOMACH DISEASE | KIDNEY PROBLEM | FAINTING or DIZZINESS |
| | RENAL DIALYSIS | INTESTINAL DISEASE | GLAUCOMA | |

X _____ DATE _____
PATIENT SIGNATURE (PARENT or GUARDIAN)

X _____ DATE _____
DOCTOR'S SIGNATURE

MEDICAL UPDATES

DATE	EXCEPTIONS	PATIENT'S SIGNATURE
_____	_____	_____
_____	_____	_____
_____	_____	_____