Medical/Dental History

Patient Name: _____ **Primary Physician**_____ **Phone**_____

Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment. Please check the box for any condition that you have now or had in the past.
(parent/Guardian: Please check the appropriate boxes concerning your child's health status)

Cardiovascular (Heart)

- High Blood Pressure ☐
- Heart Attack _____ Year ☐
- Heart Pacemaker ☐
- Heart Surgery ☐
- Irregular Heartbeat ☐
- Heart Murmur ☐
- Mitral Valve Prolapse ☐
- Rheumatic Fever ☐
- Angina/Chest Pain ☐
- Congenital Heart Defect ☐
- Take Daily Aspirin ☐
- Take Blood Thinner ☐
  - Which One_____

Derma/Musculoskeletal

- Sore Jaw Muscles/Joints ☐
- Artificial Joints ☐
- Mouth Ulcers/sores ☐
- Osteoporosis ☐
- Have you Taken/or Taking Bisphosphonates ☐

Urinary

- Urinate Frequently ☐
- Kidney Problems ☐
- Renal Dialysis ☐

Allergies (circle if yes)

Penicillin Latex Codeine
Metals Sulfa Drugs Aspirin
Acrylics Local Anesthetics

Do you take a Pre-Med?
Yes or No

Nerves & Sensory

- Severe Headaches ☐
- Fainting/Dizzy Spells ☐
- Dental anxiety ☐

Respiratory (Breathing)

- Emphysema ☐
- Lung Disease ☐
- Sinus Problems ☐
- Allergies or Hives ☐
- Asthma ☐
  - Use Inhaler? _____
- Tuberculosis (TB) ☐
- Endocrine (Hormonal) ☐
- Diabetes (Type 1 or Type 2) ☐
  - Take Insulin_____
- Thyroid Disease ☐

Other Conditions

- Enlarged Node/Gland ☐
- Use Tobacco ☐
- Use Alcohol ☐
- Drug Dependency ☐
- Tumor/Cancer ☐
- Radiation/Chemotherapy ☐
- Bad reaction to nitrous oxide ☐
- Bad reaction to local anesthetic ☐
- History of dry sockets ☐
- Allergy to the **"sugar"** in milk, (lactose Intolerant) ☐
- Allergy to the **"protein"** in milk, which would be considered a life-threatening condition ☐

Gastrointestinal (Stomach)

- Ulcers ☐
- Hepatitis ☐
  - When? _____
  - Type? _____
- Liver Disease ☐
- Cirrhosis ☐

Hematologic (Blood)

- Stroke ☐
  - When? _____
- Anemia ☐
- Prolonged Bleeding ☐
- Leukemia ☐
- HIV/AIDS ☐
- Blood Transfusion ☐

Please Circle All That Apply

Bad breath	Loose teeth
Swelling	Missing teeth
Abscess	Pain in ears/jaw
Bad taste	Sensitivity to hot
Bleeding gums	Sensitivity to cold
Bite nails	Orthodontics
Staining	Click/pop jaw
Clinch or grind	Partial/dentures
Cold sores	Difficult chewing
Dry mouth	Difficult open/close
Gag Easily	Headaches

Are you happy with your smile? ____

Women

Pregnant/Trying? Yes or No
Taking Oral Contraceptives? Yes or No
Nursing? Yes or No

Please list any other medical conditions or concerns not mentioned above that the Doctor should be aware of: _____

Have you seen a physician for a medical condition in the last 6 months? _____

Are you taking (or supposed to be taking) any medicine, drug or pills of any kind (including Aspirin and other non-prescription drugs). If so what? _____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment.

Signature: _____ **Date**_____