MEDICAL HISTORY

Patient Name: _____ Nickname: _____ Age: _____

Name of Physician: _____ Phone #: _____

Date of last physical examination: _____ Purpose: _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

PLEASE CHECK IF YOU HAVE, OR EVER HAD THE FOLLOWING:

1. hospitalization for illness or injury ❑
2. allergic reaction to:
   - ❑ aspirin
   - ❑ penicillin
   - ❑ erythromycin
   - ❑ codeine
   - ❑ local anesthetic
   - ❑ fluoride
   - ❑ metals (gold, stainless steel)
   - ❑ latex, plastic
   - ❑ other medications
3. heart problems or pacemaker ❑
4. heart murmur ❑
5. mitral valve prolapse ❑
6. scarlet fever ❑
7. rheumatic fever ❑
8. high blood pressure ❑
9. low blood pressure ❑
10. stroke ❑
11. artificial prosthesis (heart valve/joints) ❑
12. anemia or other blood disorder ❑
13. prolonged bleeding ❑
14. emphysema ❑
15. tuberculosis ❑
16. asthma ❑
17. sinus problems ❑
18. diabetes ❑
19. kidney disease ❑
20. liver disease/jaundice ❑
21. thyroid or parathyroid disease ❑
22. stomach or duodenal ulcer ❑
23. arthritis ❑
24. glaucoma ❑
25. contact lenses ❑
26. head or neck injury ❑
27. epilepsy, convulsions (seizures) ❑
28. viral infections and cold sores ❑
29. any lumps or swelling in mouth ❑
30. hives, skin rash, hay fever ❑
31. venereal disease/STD ❑
32. hepatitis (type _____) ❑
33. HIV or AIDS ❑
34. tumor, abnormal growth ❑
35. radiation therapy ❑
36. chemotherapy ❑
37. emotional problems ❑
38. psychiatric treatment ❑
39. antidepressant medication ❑
40. alcohol/drug dependency ❑
41. presently treating for illness ❑
42. aware of a change in general health ❑
43. often exhausted or fatigued ❑
44. subject to frequent headaches ❑
45. heavy smoker (1 pack or more) ❑
46. generally a nervous person ❑
47. often unhappy or depressed ❑
48. FEMALE – taking birth control pill ❑
49. FEMALE – pregnant ❑
50. MALE – prostate disorders ❑
51. other ❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment: _____

_____

Are you taking any prescription/over-the-counter drugs? _____

Please list: _____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature: _____ Date: _____

Dentist's/Hygienist Remarks: _____

Reviewed: _____ Changes: _____ Date: _____

Reviewed: _____ Changes: _____ Date: _____

Reviewed: _____ Changes: _____ Date: _____

Reviewed: _____ Changes: _____ Date: _____

DENTAL HISTORY

Referred by: _____

Previous Dentist: _____ How long? _____

Last dental exam: _____ Last dental x-ray: _____

Last dental treatment: _____

How often do you have your teeth cleaned? 3 mo. _____ 4 mo. _____ 6 mo. _____ 1 yr. or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

_____

PLEASE CHECK IF YOU HAVE, OR EVER HAD THE FOLLOWING:

1. unhappy with appearance of your teeth ..... ❑
2. unfavorable dental experiences ..... ❑
3. dental fears ..... ❑
4. preference for no dental anesthetic ..... ❑
5. problems with effectiveness or bad reactions to dental anesthetic ..... ❑
6. orthodontic treatment (braces) / when ..... ❑
7. periodontal (gum) treatment / when ..... ❑
8. bleeding gums ..... ❑
9. avoid brushing any part of your mouth ..... ❑
10. part of your mouth is sensitive to temperature ..... ❑
11. sore teeth ..... ❑
12. a burning sensation in your mouth ..... ❑
13. difficulty swallowing ..... ❑
14. an unpleasant taste or odor in your mouth ..... ❑
15. jaw problems (temporomandibular joint) ..... ❑
16. difficulty opening your mouth widely ..... ❑
17. stiff neck muscles ..... ❑
18. awaken with an awareness of your teeth or jaws ..... ❑
19. tension headaches ..... ❑
20. clench or grind your teeth ..... ❑
21. jaw clicking or popping ..... ❑
22. lost any teeth ..... ❑

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	*(Please check YES or NO)*
❑	❑	Has your present denture been relined? When? _____
❑	❑	Is your present denture a problem? Describe: _____
❑	❑	Satisfied with the appearance? _____
❑	❑	Satisfied with the comfort? _____
❑	❑	Satisfied with the chewing ability? _____
		When did you receive your first partial or complete denture? _____
		How long have you worn your present denture? _____

Patient's Signature: _____ Date: _____

Dentist's Remarks: _____

_____

_____ Rev: _____

OVER