

MEDICAL HISTORY

Patient Name _____ Birth Date _____ Today's Date _____

Physician's Name _____ Physician's Phone# _____ Date of last Physical _____

Are you under the care of a physician? Y N If yes, explain _____

Do you have or have you ever had any of the following? (Circle Y or N for each):

Y N Heart Problems(attack, stroke)	Y N Cancer, Tumors	Y N Head Injuries
Y N Heart Murmur	Y N X-Ray /Radiation Treatments	Y N Nervous/ Emotional Problems
Y N Heart Disease	Y N Recent Weight Loss	Y N Mental Disorders
Y N Artificial Heart Valves	Y N Back Problems	Y N Psychiatric Care
Y N Pacemaker	Y N Diabetes	Y N Hepatitis or Liver Disease
Y N Joint Replacement	Y N Respiratory/Lung Diseases	Y N Jaundice
Y N Circulatory Problems	Y N Asthma	Y N Chronic Diarrhea
Y N High/Low Blood Pressure	Y N Tuberculosis	Y N Sinus Problems
Y N Thyroid Problems	Y N Emphysema	Y N Allergy to Latex
Y N Blood Disease	Y N Eye Problems / Glaucoma	Y N Allergies to Medication/ Drugs/ Foods
Y N Anemia	Y N Epilepsy	Y N Arthritis
Y N Hemophilia	Y N Frequent Headaches	Y N Rheumatism
Y N Prolonged Bleeding (after injury)	Y N Dizziness/Fainting Spells	Y N Growths/ Swollen Neck Glands
Y N Rheumatic Fever	Y N HIV Positive/ ARCS	Y N Ulcers, Stomach, Intestinal Problems
Y N History of Drug Abuse	Y N Venereal Disease	Y N Hospitalization or Surgeries
Y N Recreational Drugs	Y N Use of Alcohol /Tobacco Products	Y N Phen-Fen usage

For women: Are you pregnant, nursing, or taking birth control pills? Y N If you are pregnant, how many weeks? _____

Is there any physical or medical condition or information not listed above, please record here. _____

Have you ever had any complications during and following dental treatment? Y N If yes, explain. _____

DENTAL HISTORY

Y N Do you have any specific problems/tooth aches?	Y N Do you have pain in or near your ears?
Y N Do you have any unhealed/inflamed areas around your mouth?	Y N Do you have any growths/sore spots in your mouth?
Y N Have you had any reactions or allergic symptoms to anesthetic?	Y N Have you been given local anesthetics(novocaine)?
Y N Do your gums bleed or hurt?	Y N Do you have problems with bad breath?
Y N Do you clench or grind your teeth during the day or night?	Y N Have you had any difficult extractions in the past?
Y N Are any of your teeth sore to biting pressure, hot, cold, or sweets, etc?	

If you answered yes to any of these questions, please explain: _____

The above information is accurate and complete to the best of my knowledge. If I ever have any change in health, I will inform the doctors at the next appointment without fail. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in completion of this form.

Patient/Parent/Guardian Signature and Date

Doctor Signature and Date

Dental Office Staff Signature and Date