PATIENT MEDICAL / DENTAL HISTORY

PATIENT'S NAME: ___________________________________ AGE________ DATE ________________________________

1. How do you perceive your health? (Excellent, Good, Poor) Date of Last Medical Exam ___________________________
   Name of Physician(s): _______________________________________ Phone Number: ____________________________________
   Name of Physician(s): _______________________________________ Phone Number: ____________________________________

2. DO YOU HAVE A HISTORY OF? (IF "YES," PLEASE CIRCLE)			
Cardiovascular Disease	Medication for Bones	Jaundice	Venereal Disease
Heart Surgery	Osteoporosis / Osteopenia	Hepatitis	Birth Control Pills
Artificial Heart Valve	Asthma	Diabetes	Pregnant: Yes / No
Angina	Shortness of Breath	Anemia	What Trimester: 1 2 3
Frequent Chest Pains	Cancer	Kidney Disease	Nursing Baby? Yes / No
Swelling of Ankles	Radiation Treatment	Glaucoma	Tobacco User: Dip or Smoke
High Blood Pressure	Chemotherapy	TB (Tuberculosis)	How much per day?
Stroke	Thyroid Disease	Hives, Skin Rashes	Do you consume Alcohol?
Artificial Joint	Liver Disease	HIV Virus	How much per day?

3. ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO ANY MEDICINE OR MATERIALS? (IF "YES," CIRCLE)					
Aspirin	Codeine	Hydrocodone	Tetracycline	Erythromycin	Latex
Ibuprofen	Ativan	Valium	Amoxicillin	Iodine	Metals in Jewelry
Tylenol	Percodan	Penicillin	Clindamycin	Acrylic	Household Bleach
Demerol	Others:				

****If you are taking Birth Control Pills be advised that while taking antibiotics an alternate form of birth control must be used.**

4. LIST ANY MEDICATIONS AND REASONS FOR TAKING:

5. ARE YOU REQUIRED TO TAKE ANTIBIOTIC PRE-MEDICATION FOR ANY OF THE FOLLOWING? (IF "YES," CIRCLE		
Heart Murmur or Prolapsed Valve (MVP)	Prosthetic Heart Valve	Cancer
Congenital Heart Disease	Rheumatic Fever/Rheumatic Heart Disease	Chemotherapy or Radiation Treatments
Joint Prosthesis (Hip, Knee, Etc.)	Diabetes	Other:

6. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC OR EPINEPHRINE? YES NO

7. HAVE YOU EVER HAD INSTANCES OF PROLONGED OR UNUSUAL BLEEDING? YES NO
   Circle any blood thinners you are taking: Aspirin Coumadin Plavix Other: ____________________________

8. DO YOU HAVE ANY OTHER DISEASE, CONDITIONS, OR PROBLEMS NOT LISTED ABOVE THAT YOUR DENTIST SHOULD KNOW ABOUT BEFORE PROCEEDING WITH TREATMENT? PLEASE EXPLAIN.

9. WHAT WAS THE NAME OF YOUR PREVIOUS DENTIST AND DATE OF LAST EXAM?

10. HOW DO YOU PERCEIVE YOUR DENTAL HEALTH? Circle One: EXCELLENT GOOD POOR

11. HOW CAN WE BEST MEET YOUR DENTAL NEEDS? Circle any that Apply:
    (Cleaning, Dentures, Partials, Crown & Bridge, Cosmetic Dentistry, Gum Disease, Gum Recession, Implants, Other)_______________

12. HAVE YOU EVER BEEN TOLD YOU HAVE GUM DISEASE OR ANY OTHER DENTAL CONDITION THAT THE DOCTOR SHOULD KNOW ABOUT?

13. SIGNATURE OF PATIENT (or Parent, if Patient is a minor)

DENTIST'S REMARKS: