MEDICAL HISTORY

Your mouth is a part of your body and can influence your general health. The history of illnesses you have or have had and medications you take can impact your entire body. As dentists, we want to ensure your total wellness. Thank you for answering the following questions.

Name _____ **Date**_____

Date of last health care exam _____ **What was exam for?** _____

Have you been hospitalized in the last 5 years? ***(Please circle)*** No Yes If yes, reason: _____

Are you currently receiving care? ***(Please circle)*** No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____ 2. _____ 3. _____

For the following questions, check the appropriate box. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

	YES	NO		YES	NO
Anemia			Joint Replacement		
Arthritis/Rheumatism			Kidney Disease		
Asthma			Liver Disease (including Jaundice)		
Abnormal Bleeding from a cut			Latex Sensitivity		
Cancer/ Chemotherapy/ Radiation/ Tumors			Psychosis/Depression		
Diabetes, excessive thirst			Previous Biopsies		
Dry Mouth			Recurrent Illnesses		
Dialysis			Rheumatic Fever		
Elevated Cholesterol			Sleep Apnea/ use CPAP device		
Emphysema or other Respiratory Illness			Slow-Healing Mouth Sores		
Epilepsy, Seizures, Convulsions			Sore/Enlarged Lymph Nodes		
Glaucoma			Stroke		
Heart Condition, abnormal			Thyroid Problems		
Heart Murmur (mitral valve prolapse)			TMJ (Jaw) Pain, Headaches		
Heart (surgery, disease, attack, valve replacement, pacemaker, A-fib)			Turberculosis		
Hepatitis, any form			Ulcers		
HIV positive or AIDS related Complex			Unintentional Weight Loss/ Gain		
Infections			Venereal Disease		

(Please Circle)

Are you required to Pre-Medicate before dental treatment? ..... No Yes

Women: Are you pregnant? ..... No Yes

If no, are you planning a pregnancy in the near future? ..... No Yes

Are you a nursing mother? ..... No Yes

Are you taking birth control pills? ..... No Yes

Abnormal Blood Pressure? ..... No Yes

If yes, what is it usually? (S / D)

Are you allergic to or have you had a reaction to:

a. Local anesthetics ..... No Yes

b. Penicillin or other Antibiotics ..... No Yes

c. Aspirin ..... No Yes

d. Codeine, Valium or other sedatives ..... No Yes

e. Other _____

Are you a smoker or use smokeless tobacco? ..... No Yes

If so, how much do you use per day? _____

Please list any medications you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Pharmacy of preference? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*