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San Diego, CA 92123
(858) 277-2999

DATE

PATIENT'S NAME | ATTENDING DENTIST

FORMER DENTIST | PHYSICIAN'S NAME

DATE OF LAST VISIT | DATE OF LAST CLEANING | PHYSICIAN'S ADDRESS

WHAT IS THE PURPOSE OF YOUR VISIT?

ANSWER YES OR NO TO THE FOLLOWING

Question		
DO YOU PRESENTLY HAVE ANY DENTAL PAIN OR PROBLEMS?	☐ YES	☐ NO
HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE LAST TWO YEARS?	☐ YES	☐ NO
ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	☐ YES	☐ NO
ARE YOU IN GOOD HEALTH?	☐ YES	☐ NO
HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE PAST 5 YEARS?	☐ YES	☐ NO

DATE OF LAST PHYSICIAN'S EXAMINATION | DATE BLOOD PRESSURE LAST TAKEN | READING?

ARE YOU NOW TAKING ANY MEDICATION, DRUGS, OR PILLS? ☐ YES ☐ NO IF YES, PLEASE LIST THOSE DRUGS BELOW:

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATION? (MARK APPROPRIATE BOX)

MEDICATION	YES	NO	DON'T KNOW	MEDICATION	YES	NO	DON'T KNOW	MEDICATION	YES	NO	DON'T KNOW	MEDICATION	YES	NO	DON'T KNOW
ASPIRIN				NITROUS OXIDE				PENCILLIN				NEMBUTAL			
DARVON				PERCODAN				OTHER ANTIBIOTICS				NOVOCAINE			
CODEINE				TETRACYCLINE				VALIUM				XYLOCAINE			
DEMORAL				ERYTHROMYCIN				SLEEPING PILLS				LOCAL ANESTHESIA			

ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATION OR SUBSTANCE? ☐ YES ☐ NO
IF YES, PLEASE LIST: ______

INDICATE YES (Y) OR NO (N) TO ANY OF THE FOLLOWING CONDITIONS YOU HAD OR HAVE AT THE PRESENT.

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
		ANGINA PECTORIS			ARTIFICIAL HEART VALVE			ALLERGIES OR HIVES			ABNORMAL BLEEDING			ARTHRITIS
		ARRHYTHMIAS			ARTIFICIAL JOINT			ASTHMA			BLOOD DISORDER			COLD SORES
		CONGENITAL HEART LESION			EAR PROBLEMS			BULEMIA/ANOREXIA			HEMOPHILIA			CORTISONE TREATMENT
		CONGESTIVE HEART FAILURE			EPILEPSY OR SEIZURES			CHEMOTHERAPY			LEUKEMIA			DRUG ADDICTION
		HEART DISEASE OR ATTACK			FAINTING/DIZZY SPELLS			DIABETES			ANEMIA			GONORRHEA
		HEART MURMUR			GLAUCOMA			EMPHYSEMA			BLOOD TRANSFUSION			HERPES
		HEART SURGERY			KIDNEY DISEASE			RADIATION THERAPY			CANCER			HIV OR EXPOSURE
		HIGH BLOOD PRESSURE			LIVER DISEASE			SINUS TROUBLE			HEPATITIS A (INFECTIOUS)			NERVOUSNESS
		MITRAL VALVE PROLAPSE			SCARLET FEVER			STOMACH PROBLEMS			HEPATITIS B (SERUM)			PSYCHOLOGICAL PROBLEMS
		PACEMAKER			STROKE			TUBERCULOSIS (TB)			SICKLE CELL DISEASE			RHEUMATISM
		RHEUMATIC FEVER			THYROID DISEASE			ULCERS			YELLOW JAUNDICE			SYPHILIS

COMMENTS:

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT? ☐ YES ☐ NO
IF YES EXPLAIN ______

DO YOU SMOKE? ☐ YES ☐ NO HOW MUCH? ______

FOR WOMEN ONLY

ARE YOU PREGNANT?	IF YES, WHEN DUE?	ARE YOU TAKING BIRTH CONTROL PILLS?	DO YOU ANTICIPATE BECOMING PREGNANT?
☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO

MEDICAL HISTORY UPDATE

LIST CHANGES IN MEDICAL HISTORY AT EACH APPOINTMENT AND EXPLAIN

DATE	CHANGE	PAT. INT.	DR. INT.	DATE	CHANGE	PAT. INT.	DR. INT.

Today's Date ______ Patient's Signature ______ Parent/Guardian Signature ______ DRS. INIT. ______

Adult Medical History