

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- How is your general health? Excellent Good Fair Poor
 Are you under a physician's care now? Yes No
 Have you ever been hospitalized or had a major operation? Yes No
 Have you ever had a serious head or neck injury? Yes No
 Are you taking any medications, pills, or drugs? Yes No
 Are you on a special diet? Yes No
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No

If yes, please explain: _____
 If yes, please explain: _____
 If yes, please explain: _____
 If yes, please list all medications: _____

Women:

- Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Dental Health:

- Are you afraid of seeing a dentist? Yes No Do you clench or grind your teeth while sleeping or while awake? Yes No
 Do your gums bleed while brushing or flossing? Yes No Do you have problems eating? Yes No
 Do you avoid brushing any part of your mouth because of pain? Yes No Do you have bad breath? Yes No
 Do your gums feel tender or swollen? Yes No Have you ever responded unfavorably to medical or dental care? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Tylenol Latex Local Anesthetics
 Other: Please list: _____

Do you have, or have you had, any of the following?

- | | | | | | |
|---------------------------|--|---------------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatment | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pain | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |

AUTHORIZATIONS:

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes.

Signature of patient, parent or guardian: _____ Date: _____

