PATIENT MEDICAL HISTORY – ALLERGIES

PRECAUTIONS

Family Physician _____

Phone # _____ Date of Last Physical _____

DO YOU OR HAVE YOU EVER HAD...(Circle all that apply)

Heart Murmur	High Blood Pressure	Kidney Disease	Radiation Therapy
Mitral Valve Prolapse	Low Blood Pressure	Migraine Headaches	Arthritis
Artificial Heart Valve	Blood Disorders	Epilepsy	Drug Addiction
Rheumatic Fever	Anemia	Herpes (oral-cold sores)	Psychiatric Problems
Prosthetic (artificial) Joint:	AIDS/HIV Positive	Glaucoma	Prolonged Bleeding
hip, knee, shoulder	Hepatitis A, B, or C	Thyroid Disease	Other, List:
Endocarditis	Liver Disease	Stroke	
Heart Condition	Asthma/Emphysema	Fainting Spells	
Heart Pacemaker	Tuberculosis	Diabetes	

ARE YOU ALLERGIC TO...(Circle all that apply)

Amoxicillin/Penicillin	Codeine	Aspirin	Environmental/Seasonal
Mycins	Demerol	Latex	Iodine
Other Antibiotics	Sulfa Drugs	Novocaine/Local Anesthetic	Metals

YES NO

❑ ❑ Are you now taking any medication, drugs or pills?

If yes, please list: _____

❑ ❑ Are you now or have you previously taken bisphosphanate medications, i.e. Fosamax, Actonel, Boniva, Zometa, or Aredia?

❑ ❑ Have you ever been advised by your physician or dentist to take an antibiotic prior to dental treatments?

If yes, antibiotic name: _____

❑ ❑ Are you pregnant? If yes, what month _____ Are you nursing? _____

Updates

_____

_____

_____

_____

_____

_____

PATIENT'S DENTAL HISTORY

Previous dentist _____ Date of last visit _____

What is your main concern today? _____

DO YOU EXPERIENCE FREQUENT...(Circle all that apply)

Headaches	Jaw Clicking, Popping	Snoring
Earaches	Jaw Pain	Sinus Problems
Bleeding/Tender Gums	Clenching/Grinding Teeth	Tooth Sensitivity Hot/Cold

DO YOU HAVE ANY OF THE CURRENT PROBLEMS...(Circle all that apply)

No Problems	Broken or Missing Fillings
Missing Tooth	Toothache (specify area) _____
Cracked Tooth	Broken Denture/Appliance
Chipped Tooth	

HAVE YOU EVER HAD ANY OF THE FOLLOWING DENTAL SERVICES...(Circle all that apply)

Crowns/Bridges	Wisdom Tooth Removal	Dentures - Year Made _____
Orthodontic Braces	Dental Implants	Removable Partial Denture
Gum Surgery	Bitesplint/Nightguard	Relines - Date Done _____

Do you like your smile? ❑ YES ❑ NO If not, why? _____

_____

Do you like the color of your teeth? ❑ YES ❑ NO

Do you smoke or chew tobacco? ❑ YES ❑ NO If so, how often or how much? _____

Does dental treatment make you nervous? ❑ YES ❑ NO

How can we help you feel most comfortable for dental treatment?

❑ Nitrous Oxide/Laughing Gas ❑ Explanation of Procedures ❑ Oral Sedation/Medication

Comments _____