MEDICAL DENTAL HISTORY FORM

Patient Name_______________________________________ Date______________________________________

Please help us to provide you with the best care possible. Complete the following history, furnishing description and date when possible.

Are you presently under a physician's care for any illness or problem? Yes_________ No_________

If Yes for what??? ____

List all Surgeries

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Please place an X next to Yes if it applies to you	YES
Do you have an allergy to Latex	_________
Do you have an allergy to Penicillin	_________
Do you have an allergy to Codeine	_________
Have you been hospitalized in the last 5 years	_________
Do you bruise easily	_________
Rheumatic Fever	_________
Heart Murmur	_________
Mitral Valve Prolapse	_________
Heart Surgery	_________
Artificial Heart Valves	_________
Pacemaker	_________
High Blood Pressure	_________
Stroke	_________
Seizures	_________
Artificial Joints	_________
Bleeding Problem	_________
Emphysema, Asthma or other Lung Disease	_________
Chest Pain	_________
Tuberculosis	_________
Diabetes	_________
Cancer	_________
Chemotherapy	_________
Radiation Treatments	_________
Hepatitis	_________
AIDS/HIV related Complex	_________
Liver Disease	_________
Kidney Disease	_________
Blood Transfusion	_________
Glaucoma	_________
Venereal Disease	_________
Headaches	_________
Fainting or Dizziness	_________
Thyroid Disease	_________
Do you Smoke	_________
Do you use Alcohol	_________
Do you wear contact lenses	_________
Do you have a persistent cough or cold	_________
Do you use aspirin	_________
Women: Are you pregnant	_________

Women: Are you Nursing __________
Women: Do you use Oral Contraceptives __________

Dental Related Questions

Dry Mouth/Excessive Thirst __________
Sensitive Teeth/Hot Cold Pressure Sweets __________
Cold Sores __________
Swelling __________
Bleeding Gums __________
Loose Teeth __________
Grinding __________
Jaw Pain __________
TMJ-clicking, popping of jaw __________

Previous Dentist____
Last Dental Visit____
Last Dental Cleaning____
Are you currently in Pain____

I the undersigned understand that I answered all questions to the best of my knowledge and authorize the doctor to take radiographs necessary to make a thorough diagnosis and perform a complete dental examination to determine my dental needs.

Signature Date _________________________