PATIENT MEDICAL HISTORY

Patient Name:	Nickname:

Reason for visit:	Date of last dental visit:

Physician or Clinic Name:	Physician/Clinic Phone or Location:

Pharmacy:	Pharmacy Phone:

How often do you brush? _____ How often do you floss?_____ Do you smoke or use tobacco products? _____

Sex: ____

If female, please answer the following:

Y N Are you taking Birth Control Pills?
Y N Are you pregnant? If yes, # of weeks _____
Y N Are you nursing?

Please list any medication you are now taking: _____
_____
_____

***It is especially important to know if you are taking tranquilizers, Phenobarbital or dilantin, blood thinners, steroid type medicines, aspirin, nitroglycerine, arthritis or thyroid medicine.**

Circle Y or N

Y N Are you having pain or discomfort now? If so, what? _____
Y N Do your gums bleed when you brush?
Y N Have you had periodontal or gum treatment?
Y N Have you had any undesirable treatment experience? If so, what? _____
Y N Do you have any sores or lumps in your mouth that don't heal?
Y N Are you unhappy with your smile? If so, why? _____
Y N Have you had orthodontic treatment?
Y N Are you currently under a physician's care? If so, for what? _____
Y N Have you had any illness or surgery in the past year? If so, what? _____
Y N Are you changing dentists for any particular reason? If so, why? _____

Conditions: Check all that apply

- ❑ Abdominal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Bones
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer-Chemotherapy
- ❑ Chemical Dependency/ Drug Abuse
- ❑ Congenital Heart Defect
- ❑ Congestive Heart Failure
- ❑ Dental Implants
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Eating Disorders
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever

- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A, B and/or C
- ❑ Herpes Virus
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV+ AIDS
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Organ Transplant
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

List any disease or condition you think this office should know about.

_____
_____
_____
_____

Allergies:

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Jewelry
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Other
- ❑ _____
- ❑ _____