PATIENT MEDICAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH_____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS PART OF YOUR BODY. HEALTH PROBLEMS THAT YOU HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH……	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR ……	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM_____		
4.PHYSICIAN 'S NAME_____ ADDRESS & PHONE NUMBER_____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN ….	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS…… .. PLEASE EXPLAIN_____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE…… IF YES,WHAT MEDICINES ARE YOU TAKING_____ _____ _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING…….	☐	☐
9. DO YOU BRUISE EASILY……	☐	☐
10.HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11.HAVE YOU EVER TAKEN FEN-PHEN OR REDUX……	☐	☐
12.DO YOU USE TOBACCO…….	☐	☐
14.DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT……..	☐	☐
WOMEN ONLY		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT ……	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS……	☐	☐
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTI		
LOCAL ANESTHETICS LIKE NOVOCAINE……		
PENICILLIN OR OTHER ANTIBIOTICS……	☐	☐
ASPIRIN……	☐	☐
LATEX/RUBBER……	☐	☐
	☐	☐
OTHER_____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER…..	☐	☐
SCARLET FEVER……	☐	☐
HEART DEFECT OR HEART MURMUR……	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA…….	☐	☐
PACEMAKER…… …….	☐	☐
MITRAL VALVE PROLAPSE……	☐	☐
HIGH/LOW BLOOD PRESSURE……	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE……	☐	☐
STROKE……	☐	☐
RESPIRATORY DISEASE……	☐	☐
HIVES OR SKIN RASH……	☐	☐
DIABETES……	☐	☐
AIDS OR HIV INFECTION……	☐	☐
BLOOD DISEASE……	☐	☐
ARTHRITIS OR RHEUMATISM……	☐	☐
JOINT REPLACEMENT OR IMPLANT……	☐	☐
STOMACH TROUBLE OR INTESTINAL DISEASE……	☐	☐
KIDNEY TROUBLE……	☐	☐
THYROID PROBLEMS……	☐	☐
EPILEPSY OR SEIZURES……	☐	☐
TUMORS/CANCER……	☐	☐
TUBERCULOSIS ……	☐	☐
ALLERGIES……	☐	☐
MENTAL HEALTH CARE……	☐	☐
SEXUALLY TRANSMITTED DISEASE……	☐	☐
COLD SORES/FEVER BLISTERS……	☐	☐
EATING DISORDERS……	☐	☐
CHEMICAL DEPENDENCY……	☐	☐

FOR OFFICE USE ONLY:

CURRENT MEDICATION	DOSAGE	DATE	CHANGE	PATIENT SIGNATURE	DOCTOR SIGNATURE