MEDICAL HISTORY AND DENTAL HISTORY

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your dental health. Thank you for taking the time to completely fill out this information.

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?		
Are you under a PHYSICIAN'S CARE now?		
If Yes, please explain:		
PHYSICIAN NAME PHONE (include area code)		
DATE of last PHYSICAL EXAM		
Are you PREGNANT?		
Are you having PROBLEMS now?		
Are your APPREHENSIVE about dental treatment? Please describe.		
Are you UNHAPPY with the appearance of your teeth? Please describe.		

PLEASE √ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.			Fainting			Psychiatric care		
Anaphylaxis			Food allergies			Rapid weight gain/loss		
Anemia			Glaucoma			Radiation treatment		
Arthritis (Rheumatism)			Headaches			Respiratory disease		
Artificial heart valves			Heart murmur			Rheumatic/scarlet fever		
Artificial joints			Heart problems (please describe)			Shingles		
Asthma						Shortness of breath		
Atopic (Allergy Prone)			Hemophilia (Abnormal bleeding)			Skin rash		
Back problems			Herpes			Sleep Apnea		
Blood disease			Hepatitis			Spina Bifida		
Cancer			High blood pressure			Stroke		
Chemical dependency			Jaw pain			Surgical implant		
Chemotherapy			Kidney disease or malfunction			Swelling of feet or ankles		
Circulatory problems			Liver disease			Thyroid disease/malfunction		
Cortisone treatments			Material allergies (Latex, wool,			Tobacco habit		
Cough (Persistent)			metal, chemicals			Tonsillitis		
Cough up blood			Mitral valve prolapse			Tuberculosis		
Diabetes			Nervous problems			Ulcer/Colitis		
Epilepsy			Pacemaker/heart surgery			Venereal disease		

Medications: What medications, including vitamins, supplements, or over-the-counter medications, are you currently taking?

_____

_____

Have you ever taken any of these medications for Osteoporosis? (please circle) Fosamax, Actonel, Boniva, Aredia, Zometa

Have you ever taken any cancer drugs? Yes No If yes, _____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.) Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances? If yes, please list.

_____

_____

Patient Name_____ Date_____

Signature _____