



Medical and Dental History

Name _____

Date of Birth _____

Occupation _____

__Male __Female

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health?..... Yes No

2. Has there been any change in your general health in the past year?..... Yes No

If yes, explain _____

3. My last physical examination was _____

4. Are you now under the care of a physician?..... Yes No

If yes, explain _____

5. The name and telephone # of my physician is _____

6. Have you been hospitalized or had a serious illness within the past 5 years?..... Yes No

If yes, what was the problem? _____

7. Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves..... Yes No

b. Mitral valve prolapse, heart murmur, congenital heart defects..... Yes No

c. Cardiovascular disease (heart attack, coronary blockage, high blood pressure, stroke) Yes No

(1) Do you have pain in your chest upon exertion?..... Yes No

(2) Are you ever short of breath after MILD exercise?..... Yes No

(3) Do your ankles swell?..... Yes No

(4) Do you get short of breath when you lie down, or do you require extra pillows

when you sleep?..... Yes No

(5) Do you have a cardiac pacemaker?..... Yes No

d. Allergy/Sinus trouble/hay fever..... Yes No

e. Emphysema/Cystic Fibrosis..... Yes No

f. Asthma or any difficulty breathing..... Yes No

g. Hives or skin rash..... Yes No

h. Fainting spells or Seizures..... Yes No

i. Diabetes..... Yes No

(1) Do you have to urinate more than six times a day?..... Yes No

(2) Are you thirsty much of the time?..... Yes No

(3) Does your mouth frequently become dry?..... Yes No

j. Hepatitis, jaundice, or liver disease..... Yes No

k. Arthritis..... Yes No

l. Inflammatory rheumatism (painful swollen joints)..... Yes No

m. Ulcers/Colitis..... Yes No

n. Kidney trouble/disease..... Yes No

o. Tuberculosis..... Yes No

p. Do you have a persistent cough or cough up blood?..... Yes No

q. Venereal Disease..... Yes No

r. AIDS (Acquired Immune Deficiency Disorder)..... Yes No

s. Other Immune Disorders (Auto-immune disorders such as lupus)..... Yes No

t. Artificial Joints (knee/hip replacements)..... Yes No

u. Glaucoma..... Yes No

- v. Hearing Disorder/hearing aides..... Yes No
- w. Drug or Alcohol abuse..... Yes No
- x. Smoking Habit..... Yes No
- 8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No
 - (1) Do you bruise easily?..... Yes No
 - (2) Have you ever required a blood transfusion?..... Yes No
- 9. Do you have any blood disorder such as hemophilia, anemia..... Yes No
- 10. Have you had surgery or radiation treatment for a tumor, growth, or other condition of your head and neck?..... Yes No
- 11. Are you taking any drug or medicine?..... Yes No

If yes, what? _____

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- 12. Are you taking any of the following:
 - a. Antibiotics or sulfa drugs..... Yes No
 - b. Anticoagulants (blood thinners)..... Yes No
 - c. Medicine for high blood pressure..... Yes No
 - d. Cortisone (steroids)..... Yes No
 - e. Tranquilizers..... Yes No
 - f. Antihistamines..... Yes No
 - g. Aspirin..... Yes No
 - h. Insulin, Tolbutamide (Orinase) or similar drug..... Yes No
 - i. Digitalis or drugs for heart attack..... Yes No
 - j. Nitroglycerin (for angina)..... Yes No
 - k. Oral contraceptive or other hormonal therapy..... Yes No
 - l. Other drug(s) not listed..... Yes No

- 13. Are you allergic or have you reacted adversely to any of the following:
 - a. Local anesthetics..... Yes No
 - b. Penicillin/Tertacycline/Erthyromycin/Sulfa Yes No
 - c. Barbiturates, sedatives, sleeping pills..... Yes No
 - d. Aspirin/Ibuprofen..... Yes No
 - e. Iodine..... Yes No
 - f. Codeine, Vicodin, or other narcotics..... Yes No
 - g. Latex..... Yes No
 - h. Other drugs, substances not listed..... Yes No

If yes, what? _____

- 14. Have you had difficulty with any previous dental treatment?..... Yes No

If yes, please explain _____

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- 15. Do you have any disease, condition, or problem not listed above?..... Yes No

If yes, please explain _____

- 16. Are you employed in any situation that exposes you regularly to x-rays or other ionizing Radiation?..... Yes No

- 17. Are you wearing contact lenses?..... Yes No

- 18. Do you suffer from any disability?..... Yes No

If yes, please explain _____

FOR WOMEN

- 19. Are you pregnant?..... Yes No

If yes, when is your due date? _____

- 20. Are you nursing?..... Yes No

21. Why have you come to the dentist today? _____
22. Are you in pain?..... Yes No
If yes, please explain _____
23. Have you ever had temporomandibular joint and/or occlusal problems?..... Yes No
If yes, please explain _____
24. Do you clench or grind your teeth?..... Yes No
25. Have you ever been treated for gum disease?..... Yes No
a. Do your gums ever bleed?..... Yes No
b. Are your gums ever swollen and /or tender?..... Yes No
c. Do you have bad breath or a bad taste in your mouth?..... Yes No
26. When was your last visit to the dentist? _____
27. Do you like your smile?..... Yes No
If not, what would you change or do to make it better? _____
28. What is your main concern about your dental health? _____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status at each visit. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. I understand that I will be informed about such procedures.

Signature of Patient (or Parent/Guardian if minor patient) Date _____

OFFICE NOTES

ASA CLASSIFICATION 1 2 3 4

TREATMENT MODIFICATION NEEDED? _____ YES _____ NO
If yes, describe _____

PHYSICIAN CONSULT NECESSARY? _____ YES _____ NO

CHIEF COMPLAINT: _____

HOW SOON IS COMPLAINT TO BE TAKEN CARE OF? _____