

MEDICAL DENTAL HISTORY

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask.

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

Name _____ Occupation _____

Home Address _____ Employed By _____

City _____ Zip _____

Home Telephone _____ Business Telephone _____

Marital Status _____ Business Address _____

Social Security # _____ Age _____ Birth date _____ Sex _____

Parent or Spouse's Name _____ SS# _____

Parent or Spouse's Employer _____

Business Address _____

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever needed antibiotic coverage before a dental appointment? | <input type="checkbox"/> | <input type="checkbox"/> | Are you now taking or have you ever had radiation or chemotherapy for a disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a full mouth series of x-rays (18 film) or panoramic x-ray in the last 3 years? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking any drugs or medication if yes, list: | <input type="checkbox"/> | <input type="checkbox"/> | Have you had your wisdom teeth or 3rd molars extracted? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to any drugs? If yes, list: | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |

Do you have or have you had any of the following diseases or problems:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular diseases? | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers? |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | Nervous condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | Drug or alcohol dependency? |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever? | <input type="checkbox"/> | <input type="checkbox"/> | Goiter or thyroid disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve collapse? | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions or epilepsy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia or blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Frequent nose bleeds? |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or hay fever? | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted diseases? |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | Artificial joints or valves? |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney trouble? | <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic devices? |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice or liver disease? | <input type="checkbox"/> | <input type="checkbox"/> | Periodontal or gum disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis: If yes, what type? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Reaction to local anesthetic? (ie Novocaine) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion? When? |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion? When? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Oral habits? (ie smoking, chewing tobacco, thumb sucking, grinding) |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV positive? | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Temporal Mandibular Disorder? (TMJ) | | | |

Physician's name, address, and phone _____

Last visit to a dentist and type of treatment _____

Who can we thank for referring you? _____

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____