

MEDICAL HISTORY

Name: _____

Date: _____

Reason for this visit _____

Last Dental Visit _____

Referring Dentist Name _____

Y N	Do you require premedication for dental treatment?	Y N	Are you currently in pain?
Y N	Have you ever had serious problem or difficulty associated with any previous dental work?	Y N	Do you know or have you ever experienced problems with TMJ?
Y N	Do your gums ever bleed?	Y N	Do you have any sores or lumps in your mouth?
Y N	Do you clench or grind your teeth?	Y N	Have you ever had periodontal treatment?
Y N	Are you in good health?	Y N	Do you catch food between your teeth excessively?
Y N	Have there been any changes in your health within the past year?	Y N	Have you ever taken prescription medication for Osteoporosis?
	Physician's Name Phone #	Y N	Do you have a persistent cough or need to clear your throat not associated with a known illness, lasting more than 3 weeks?
Y N	Have you ever had any abnormal bleeding?	Y N	Do you use any form of tobacco?
Y N	Do you bruise easily?	Y N	Do you take Aspirin daily?
Y N	Have you ever required a blood transfusion?	Y N	Do you have any disease, condition or problem not listed above that you think We should know about? (Explain on reverse)
Y N	Are you pregnant or think you may be pregnant?	Y N	Are you taking any medications? If yes, please list below.
Y N	Are you nursing?		
Y N	Are you taking birth control pills?		

	Are you allergic to or have you had reactions to any of the following?		Are you allergic to or have you had reactions to any of the following?
Y N	Local anesthetics like Novacaine?	Y N	Aspirin
Y N	Penicillin	Y N	Latex
Y N	Sulfa Drugs	Y N	Any metals(e.g. Nickel, mercury, etc.)
Y N	Codeine	Y N	Any other allergies (please list):
	Do you have or have you ever had any of the following?		Do you have or have you ever had any of the following?
Y N	Rheumatic/Scarlet Fever	Y N	Arthritis or Rheumatism
Y N	Joint replacement	Y N	Heart Murmur or Defect
Y N	Pacemaker	Y N	Mitral Valve Prolapse
Y N	Shortness of breath	Y N	Kidney trouble
Y N	Chest pain	Y N	Tuberculosis
Y N	Heart surgery	Y N	Chemotherapy
Y N	Cancer	Y N	Seizures or seizure disorder
Y N	High blood pressure	Y N	Anemia
Y N	Low blood pressure	Y N	Stomach Ulcer/ Acid Reflux
Y N	Diabetes	Y N	Stroke
Y N	Hepatitis	Y N	Asthma
Y N	Fainting or dizzy spells	Y N	Sinus Trouble
Y N	Hypo/Hyper Thyroid	Y N	Cold sores
Y N	Hypoglycemia	Y N	HIV or AIDS
Y N	Allergies		