Feb. 2004

5 Medical History

Do you have a personal physician? ❑ No ❑ Yes

Physician's Name _____

Phone # _____ Date of last visit _____

Are you currently under the care of a physician for an active medical problem? ❑ No ❑ Yes

Please explain _____

Are you taking any prescription or over-the-counter drugs? ❑ No

If ❑ Yes, please list each one:

Other Physicians: _____

For Women: Are you taking birth control pills? ❑ No ❑ Yes
(birth control can be inactivated by some antibiotics)
Are you pregnant? ❑ No ❑ Yes Week # _____
Are you nursing? ❑ No ❑ Yes

	Name of Drug	How Much(mg)	How often (frequency)	Reason for taking medication
1.				
2.				
3.				
4.				
5.				

Did you ever have any of the following diseases or medical problems?

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes/Tuberculosis (TB)
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Chest Pain
Y N Heart Surgery/Pacemaker
Y N Hemophelia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Marijuana use
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers/Colitis
Y N Venereal Disease
Y N Recent Hospitalization

Please list any serious medical condition(s) that you may have ever had:

_____

_____

Do you smoke or use tobacco in any form (chew, snuff)? ❑ Y ❑ N
If yes, how many packs a day? _____
Do you use alcoholic beverages? ❑ Y ❑ N
If yes, how many drinks per week? _____

Are you allergic to any of the following drugs?

Y N Penicillin
Y N Amoxicillan
Y N Erythromycin
Y N Clindamycin
Y N Dental Anesthetics
Y N Sulfa
Y N Aspirin
Y N Codeine
Y N Oxycodone

Please list any other drug allergies: _____

Do you need to be premedicated before dental treatment?
❑ Yes ❑ No ❑ Don't know

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Signature

6 Dental History

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? ❑ Yes ❑ No
Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No
Your current dental health? ❑ Good ❑ Fair ❑ Poor
Do you like your smile? ❑ Yes ❑ No

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the C.D.C. and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____
Doctor's Comments _____

_____