

Medical History

Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Reason for this visit _____ Last dental visit _____
Referring Dentist Name _____

(Please circle Y for Yes and N for No)

- | | | | |
|-----|---|-----|---|
| Y N | Do you require antibiotics before dental treatment? | Y N | Are you currently in pain? |
| Y N | Have you ever had serious/difficult problem associated with any previous dental work? | Y N | Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? |
| 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 ever catch food between teeth? |
| Y N | Have there been any changes in your health within the past year?

_____ | Y N | Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates? |
| | Date of your last physical exam _____
Physician's Name _____
Phone # _____ | Y N | Do you or have you used controlled substances? |
| Y N | Have you ever been hospitalized for any surgical operation or serious illness?
Please Explain _____ | Y N | Have you had any recent unexplained weight loss or weight gain? |
| Y N | Are you taking any medications, including non-prescriptions medicines?
If yes, what medications are you taking

_____ | Y N | Women Only: Are you pregnant or think you may be pregnant? |
| | | Y N | Are you nursing? |
| | | Y N | Are you taking birth control pills? |
| Y N | Have you ever had any abnormal bleeding? | Y N | Do you have a persistent cough or throat clearing not associated with a known illness, lasting more than 3 weeks? |
| Y N | Do you bruise easily? | | |
| Y N | Have you ever required a blood transfusion? | | |
| Y N | Do you use any form of tobacco? | Y N | Do you have any disease, condition or problem not listed above that you think we should know about? |
| | Are you allergic to or have you had reactions to: | | |
| Y N | Local anesthetics like Novocaine | Y N | Penicillin or other antibiotics |
| Y N | Sulfa drugs | Y N | Barbiturates, sedatives, or sleeping pills |
| Y N | Aspirin | Y N | Iodine |
| Y N | Any metals (e.g. nickel, mercury, etc.) | Y N | Latex/Rubber |
| Y N | Other (please list) _____ | | |

Continued: Circle Y for Yes and N for No

Do you have or have you ever had the following:

- | | | | |
|-----|---------------------------------------|-----|---------------------------------|
| Y N | Rheumatic fever | Y N | Arthritis or rheumatism |
| Y N | Scarlet fever | Y N | Joint replacement or implant |
| Y N | Heart defect or heart murmur | Y N | Stomach ulcer |
| Y N | Chest pain | Y N | Kidney trouble |
| Y N | Shortness of breath | Y N | Tuberculosis |
| Y N | Pacemaker | Y N | Cough that produces blood |
| Y N | Heart surgery | Y N | Chemotherapy (cancer, Leukemia) |
| Y N | High/Low blood pressure | Y N | Epilepsy or seizures |
| Y N | Congenital heart problem | Y N | Anemia |
| Y N | Hepatitis, jaundice, or liver disease | Y N | Nervousness |
| Y N | Stroke | Y N | Tonsillitis |
| Y N | Sinus trouble | Y N | Tumors |
| Y N | Lung or breathing problems | Y N | Chemical dependency |
| Y N | Asthma or hay fever | Y N | Mitral valve prolapse |
| Y N | Hives or skin rash | Y N | Cortisone treatment |
| Y N | Fainting or dizzy spells | Y N | Cold sores/fever blisters |
| Y N | Diabetes | Y N | Hypoglycemia |
| Y N | Aids or HIV infection | | |
| Y N | Thyroid problems | | |
| Y N | Allergies | | |

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: _____ Date: _____