DENTAL/MEDICAL HISTORY

Patient Name: (Print) _____ Date of Birth: _____
Last First

Name of Medical Doctor: _____ Date of Last Physical Exam: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

List all the medications, including herbal remedies, you are taking:	List all medications or drugs you are allergic to:
_____	_____
_____	_____
_____	_____

Do you have a history of:

	Yes	No		Yes	No		Yes	No
AIDS:			Heart murmur:			Psychiatric treatment:		
Anemia:			Heart Surgery:			Pacemaker:		
Arthritis:			Heart trouble:			Rheumatic fever:		
Artificial heart valves:			Hepatitis:			Sinus trouble:		
Asthma:			High blood pressure:			Stroke:		
Cancer or tumor:			HIV positive:			Tuberculosis:		
Diabetes:			Joint replacement:			Ulcers:		
Epilepsy/Seizures:			Kidney disease:			Venereal disease:		
Glaucoma:			Liver disease:			None of the above:		

1. Have you been treated by a physician or hospitalized in the past year? ..... Yes☐ No☐
   If **Yes**, explain: _____
2. Has there been any change in your general health in the past year? ..... Yes☐ No☐
   If **Yes**, what? _____
3. Have you had any unusual reaction to "novocaine" or local anesthetic? ..... Yes☐ No☐
4. Have you ever had problems with prolonged bleeding from a cut, injury or tooth extraction? ..... Yes☐ No☐
5. Have you ever used, or are you currently using any narcotic drugs? ..... Yes☐ No☐
6. Pregnant or the possibly pregnant? If **Yes**, when due: _____ ..... Yes☐ No☐
7. Taking birth control pills or other hormones? ..... Yes☐ No☐
8. Is there anything related to your medical history that you have not indicated above? ..... Yes☐ No☐
   If **Yes**, explain: _____
9. Do you use tobacco? Yes☐ No☐ If "Yes," what kind? _____ How often? _____ How long? _____
10. Are you in a substance abuse, recovery program? ..... Yes☐ No☐

Do you presently have or have had...

11. Pain or discomfort in the mouth, face or jaws? ..... Yes☐ No☐
12. Bleeding or sensitive gums? ..... Yes☐ No☐
13. Aching or sensitive teeth? ..... Yes☐ No☐
14. Have you had an injury to your face or jaw? ..... Yes☐ No☐
15. Have you had serious trouble associated with any previous dental treatment? ..... Yes☐ No☐
16. Do you feel nervous or uneasy about having dental treatment? ..... Yes☐ No☐
17. Date of last dental treatment: _____
18. My dental problem now is _____

Patient/Guardian _____ Date _____

ASA	Antibiotic Pre-med	Allergies	Hepatitis	Heart Condition	Medication	Anesthetic	Nitrous Oxide