CURRENT MEDICAL HISTORY:

ADULT MEDICAL/DENTAL HISTORY

Do you have pain or discomfort at this time? .... Yes/No
Have you been a patient in the hospital during the past two years? .... Yes/No
Have you been under the care of a medical doctor during the past two years? If "Yes," reason: .... Yes/No
Physician's Name ______ Address ______ Phone ______
Have you taken any medication or drugs in the past two years? .... Yes/No
Are you now taking any medication, drugs or pills? If yes, please list below: .... Yes/No
Are you presently taking a blood thinner? (coumadin, heparin, or aspirin) .... Yes/No
If so, what are you taking and how often? ______
Have you ever taken Fosamax, Boniva, Actonel, Didronel, Skelid or any other drugs for osteoporosis? .... Yes/No
(If yes, please circle the drug you have taken)
Are you currently taking this medication? .... Yes/No

CURRENT MEDICATION	DRUG	DOSE	REASON TAKING

Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ....
If yes, please list below:

SULFA DRUGS .... YES____ NO____	PENICILLIN........ YES____ NO____	CODEINE........ YES____ NO____
ASPIRIN........ YES____ NO____	IBUPROFEN........ YES____ NO____	TETRACYCLINE........ YES____ NO____
LATEX ALLERGY... YES____ NO____	OTHER .... YES____ NO____	______

Have you ever been told that you should be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Disease or Attack .... Yes / No	Kidney Trouble .... Yes / No	Hepatitis B (serum) .... Yes / No
Angina Pectoris .... Yes / No	Stomach Ulcers .... Yes / No	A.I.D.S. .... Yes / No
Congenital Heart Disease .... Yes / No	Diabetes .... Yes / No	H.I.V. Positive .... Yes / No
Heart Murmur .... Yes / No	Thyroid Problems .... Yes / No	Cold Sores/Fever Blisters .... Yes / No
High Blood Pressure .... Yes / No	Glaucoma .... Yes / No	Blood Transfusion .... Yes / No
Endocarditis .... Yes / No	Cosmetic Surgery .... Yes / No	Hemophilia .... Yes / No
Mitral Valve Prolapse .... Yes / No	Emphysema .... Yes / No	Anemia .... Yes / No
Artificial Heart Valve .... Yes / No	Chronic Cough .... Yes / No	Sickle Cell Disease .... Yes / No
Heart Pacemaker .... Yes / No	Tuberculosis .... Yes / No	Bruise Easily .... Yes / No
Rheumatic Fever .... Yes / No	Asthma .... Yes / No	Liver Disease .... Yes / No
Arthritis .... Yes / No	Allergies or Hives .... Yes / No	Yellow Jaundice .... Yes / No
Rheumatism .... Yes / No	Sinus Trouble .... Yes / No	Epilepsy or Seizures .... Yes / No
Cortisone Medicine .... Yes / No	Radiation Therapy .... Yes / No	Fainting or Dizzy Spells .... Yes / No
Drug Addiction .... Yes / No	Chemotherapy .... Yes / No	Nervousness .... Yes / No
Head or Jaw Injuries .... Yes / No	Malignancies .... Yes / No	Psychiatric Treatment .... Yes / No
Stroke .... Yes / No	Hepatitis A (infectious) .... Yes / No	Hearing Loss .... Yes / No
Artificial Joints (Hip, Knee, etc.) .... Yes / No		

DO YOU SMOKE?........ YES____ NO____ NO. OF PACKS PER DAY? ______ NO. OF YEARS USED? ______
DO YOU DIP OR CHEW?...... YES____ NO____ AMOUNT USED ______ NO. OF YEARS USED? ______

Do wounds heal slowly or present other complications? .... Yes____ No____
Are you on a special diet? .... Yes____ No____
Has your medical doctor ever said you have a cancer or tumor? If yes, please list: .... Yes____ No____
Do you have any reason to suspect you are not in good health or have any disease or condition not listed? .... Yes____ No____

For Women Only

Are you pregnant? ☐ Yes. What Month? ______ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

DENTAL HISTORY

REASON FOR VISIT ______
How Long Has It Been Since Your Last Thorough Dental Exam? ______ X-RAYS ______ CLEANING ______
NAME OF PREVIOUS DENTIST ______ CITY ______ STATE ______

Please circle the appropriate answer:

1. Happy with appearance of teeth & smile? .... Yes / No
2. Unusual/frequent pain in: Yes / No
   Teeth☐ Jaw Joints☐ Jaws☐ Ears☐
3. Aware of grinding or clenching your teeth? .... Yes / No
4. Does food generally wedge between certain teeth? .... Yes / No
5. Have you worn braces? .... Yes / No
6. Gums bleed when brushing? .... Yes / No
7. Have you been told you have periodontal disease? .... Yes / No
8. Partial Denture .... Yes / No
9. Do you expect to have dentures in the future? .... Yes / No
10. Bad experience related to dental treatment? .... Yes / No
11. Frightened by treatment? .... Yes / No
12. Would you prefer Nitrous Oxide (Laughing Gas)? .... Yes / No

I understand the information is necessary to provide me with dental care in a safe and efficient manner I have answered all questions truthfully and to the best of my knowledge.

Patient Signature ______ **Date** ______