Medical History

Patient's Name___________________________________Date of Birth_______________Sex M F

Street Address____________________________________City__________State_______ Zip_______

Employment____Occupation_______________________

Patient's Social Security Number:__________________________

Home Phone #______________Work Phone #_______________ext_______Cell Phone #___________

Spouse's name________________Contact#_______________Emergency Contact/#________________

Other family members who are also patients____

Who recommended us to you?____

CIRCLE ANY OF THE FOLLOWING YOU HAVE EVER HAD:

Artificial Heart Valve	Diabetes	Tuberculosis	Osteoporosis
Mitral Valve Prolapse	Epilepsy	High Blood Pressure	HIV
Heart Murmur	Hepatitis A or B	Asthma	Heart Trouble
Artificial Joint Replacement	Hepatitis C	Chemotherapy	Rheumatic Fever
Bleeding Disorder	Glaucoma	Pacemaker	
Congenital Heart Defect			

MEDICAL HISTORY

YES NO

___ ___Have you ever had an unusual reaction or allergy to any drug, anesthetic, or latex?
If so, what?____

___ ___Are you currently taking any drugs or medications? If so,
what?__________________________

___ ___Are you currently under the care of a physician? If so,
why?______________________________

___ ___Have you ever had serious trouble with prolonged bleeding after a cut or injury?

___ ___Women: Are you pregnant? Expected delivery
date:____________________________________

___ ___Have you ever had serious trouble associated with any previous dental treatment?
If so, please
explain____

___ ___Do you smoke or use smokeless tobacco? Use per day:________ For how many years?___

___ ___Do you consume more than seven drinks of alcohol per week?

___ ___Have you ever been diagnosed with periodontal disease or referred to a periodontist?

___ ___Would you like to be given a prescription for a sedative to take prior to your dental
appointments? Someone will need to drive you to and from your appointment.

___ ___Is there anything about your teeth you would like to change? If so what?
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