The New Art of Dentistry • Medical History

Patient Name_____ Age _____ Physician's Name & Clinic_____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

- ❑ AIDS/ HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Arthritis
- ❑ **Artificial Heart Valve**
- ❑ **Artificial Joint**
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ **Congenital Heart Defect**
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Crohn's Disease
- ❑ Diabetes
- ❑ Dry Mouth
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Fainting Spells
- ❑ Glaucoma
- ❑ Heart Failure
- ❑ Heart Disease/Attack
- ❑ Heart Pacemaker
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes/ Cold Sores
- ❑ High Blood Pressure
- ❑ Hypoglycemia
- ❑ **Infective Endocarditis**
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Lupus
- ❑ Pain in Jaw Joints
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Rheumatism
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus trouble
- ❑ Stomach Disorder
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Veneral Disease

Are you taking any medication at his time?..... ❑ Yes ❑ No; if Yes, please list:

Name of pharmacy & phone number_____

Date of your last physical_____

Have you been under the care of a physician in the past two years? .... ❑ Yes ❑ No; if Yes, for what condition?_____

Have you been a patient in the hospital during the past two years?..... ❑ Yes ❑ No

Has your physician, cardiologist, or orthopedist told you that you may require antibiotics prior to dental treatment?..... ❑ Yes ❑ No

Have you ever had an eating disorder? ..... ❑ Yes ❑ No; if Yes, describe_____

Do you smoke or chew tobacco? ..... ❑ Yes ❑ No; if Yes, type_____ frequency_____

Do you use controlled substances?..... ❑ Yes ❑ No; if Yes, describe_____

Is there any additional information you wish to share?_____

ALLERGIES – ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

- ❑ Aspirin
- ❑ Metal
- ❑ Sulfa
- ❑ Latex
- ❑ Codeine
- ❑ Erythromycin
- ❑ Penicillin
- ❑ Acrylic
- ❑ Local Anesthetics
- ❑ Other

WOMEN ONLY:

Are you pregnant? ..... ❑ Yes ❑ No

Are you nursing?..... ❑ Yes ❑ No

Are you using oral contraceptives?..... ❑ Yes ❑ No

DENTAL HISTORY:

Are you having any pain or discomfort at this time? ..... ❑ Yes ❑ No; if Yes, please explain_____

Have you ever had periodontal (gum) treatment? ..... ❑ Yes ❑ No

Have you ever had orthodontic (braces) treatment? ..... ❑ Yes ❑ No

Do you like your smile? ..... ❑ Yes ❑ No

How many times a week do you brush?_____ Floss?_____

Are your teeth sensitive to hot, cold, or anything else? ..... ❑ Yes ❑ No

Have you had any permanent teeth removed? ..... ❑ Yes ❑ No

Have you ever responded adversely to dental treatment?..... ❑ Yes ❑ No

Do you feel very nervous about having dental treatment?..... ❑ Yes ❑ No

Name of previous dentist _____ Date of last dental exam or treatment _____

Additional Comments_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent, or Guardian _____ Date _____