Medical and Dental History

Name: _____ **Chart #** _____ **Date** _____

Please, circle "yes or no" to each item.

1. Are you currently under the care of a physician? **Yes No**
Please list reason: _____

2. Are you taking any prescription or over-the-counter drugs? **Yes No**
Please list each one: _____
_____
_____

3. List date's of all surgeries you have had: _____
_____

4. Do you bleed excessively when you are injured? **Yes No**

5. *For Women:* Are you pregnant? **Yes No** Are you nursing? **Yes No** Are you taking Birth Control? **Yes No**

6 Are you are currently taking or have taken Bisphosphonate (Boniva, Fosamax, Actonel, Est.) in the past? **Yes No**

7. When you exercise do you ever have to stop because of pain in your chest, shortness of breath, very tired? **Yes No**
Please explain: _____

8. Do you ever wake up from sleep and feel shortness of breath? **Yes No**

9. Do you smoke or chew tobacco? **Yes No** If yes, how many packs a day? _____

10. Have you ever had any periodontal treatment or Orthodontic corrections: Gum Surgery or Braces? **Yes No**
Please explain & give approximate date of completion: _____

Indicate which of the following you have had or have at the present time:

CARDIOVASCULAR			RESPIRATORY			OTHERS		
High Blood Pressure	YES	NO	Nose obstruction	YES	NO	Artificial Joints (hip, knee)	YES	NO
Stroke	YES	NO	Persistent cough	YES	NO	Kidney Disease	YES	NO
Chest pain/tightness	YES	NO	Sinus infection	YES	NO	Ulcers	YES	NO
Arteriosclerosis	YES	NO	Chronic Cough	YES	NO	Glaucoma	YES	NO
Heart failure	YES	NO	Tuberculosis	YES	NO	Cancer	YES	NO
Heart Disease or Attack	YES	NO	Asthma	YES	NO	Arthritis	YES	NO
Angina Pectoris	YES	NO	Hoarseness	YES	NO	Rheumatism	YES	NO
Congenital Heart Disease	YES	NO	Emphysema	YES	NO	Radiation Therapy	YES	NO
Heart Murmur	YES	NO				Chemotherapy	YES	NO
Mitral Valve Prolapse	YES	NO	**DIGESTIVE**			Venereal Disease	YES	NO
Artificial Heart Valve	YES	NO	Difficulty swallowing	YES	NO	AIDS	YES	NO
Heart Pacemaker	YES	NO	Heartburn	YES	NO	HIV Positive	YES	NO
Heart Surgery	YES	NO	Abdominal pain	YES	NO	Cold Sores/ Fever Blisters...	YES	NO
Rheumatic Fever	YES	NO	Liver Disease	YES	NO	Blood Transfusion	YES	NO
			Yellow Jaundice	YES	NO	Hemophilia	YES	NO
Explain: _____			Hepatitis A, B, or C	YES	NO	Anemia	YES	NO
_____						Sickle Cell Disease	YES	NO
_____			**ENDOCRINE**			Bruise Easily.....	YES	NO
_____			Diabetes	YES	NO	Epilepsy or Seizures	YES	NO
_____			Thyroid Problems	YES	NO	Fainting or Dizzy Spells	YES	NO
_____			Adrenal Problems	YES	NO	Tumors	YES	NO
			Cortisone Medicine	YES	NO	Drug Addiction	YES	NO

11. Do you have or have you had any disease, condition, or problem not listed? **Yes No** **If yes, please list:**
_____

12. Indicate which of the following you may or may not be allergic to:
Latex Gloves **Yes No** Codeine **Yes No** Penicillin **Yes No** **Please list any other allergies you have:**
_____

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

Emergency contact name _____ **Tel #** _____
Signature of Patient or Guardian (if patient is under 18 years of age) _____**Date:** _____

Reviewed By _____ **Date** _____