

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
	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
 YES NO	Fainting or Dizzy Spells YES NO
	Thyroid Problems YES NO	Tumors YES NO
	Adrenal Problems YES NO	Drug Addiction YES NO
	Cortisone Medicine YES NO	

Explain: _____

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 _____