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: ____
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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 ……………..	Nose obstruction ………………	Artificial Joints (hip, knee) ….
Stroke …………………………………	Persistent cough ……………….	Kidney Disease …………………..
Chest pain/tightness …………….	Sinus infection ………………….	Ulcers ………………………………
Arteriosclerosis …………………….	Chronic Cough ………………….	Glaucoma ………………………….
Heart failure ………………………..	Tuberculosis …………………….	Cancer ………………………………
Heart Disease or Attack ………..	Asthma …………………………….	Arthritis ……………………………
Angina Pectoris …………………….	Hoarseness ………………………	Rheumatism ………………………
Congenital Heart Disease ……..	Emphysema ………………………	Radiation Therapy ……………..
Heart Murmur ………………………		Chemotherapy …………………..
Mitral Valve Prolapse …………..	**DIGESTIVE**	Venereal Disease ……………….
Artificial Heart Valve …………….	Difficulty swallowing …………	AIDS …………………………………
Heart Pacemaker ………………….	Heartburn …………………………	HIV Positive ………………………
Heart Surgery ……………………….	Abdominal pain …………………	Cold Sores/ Fever Blisters…
Rheumatic Fever …………………..	Liver Disease …………………….	Blood Transfusion ……………..
	Yellow Jaundice …………………	Hemophilia ……………………….
Explain: _______________________	Hepatitis A, B, or C ……………	Anemia ……………………………..
________________________________		Sickle Cell Disease ……………
________________________________	**ENDOCRINE**	Bruise Easily……………………..
________________________________	Diabetes ……………………………	Epilepsy or Seizures …………..
________________________________	Thyroid Problems ……………..	Fainting or Dizzy Spells ………
________________________________	Adrenal Problems ……………..	Tumors ……………………………..
	Cortisone Medicine …………..	Drug Addiction …………………..

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