# MEDICAL and DENTAL HISTORY

**PATIENT NAME:**_____ **DATE OF BIRTH:**_____

**PHYSICIAN'S NAME:**_____ **PHONE:**_____

**PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:**

| | | | |
|---|---|---|---|
| 1. | Do you consider yourself to be in good health? | YES | NO |
| 2. | Are you now or have you been under a physician's care within the past year? | YES | NO |
| | If Yes, specify condition being treated_____ | | |
| 3. | Do you have or have you ever had any heart or blood problems? | YES | NO |
| 4. | Have you ever been told that you have a heart murmur? | YES | NO |
| 5. | Do you have or have you ever had high blood pressure? | YES | NO |
| 6. | Do you bleed or bruise easily? | YES | NO |
| 7. | Are you subject to fainting? | YES | NO |
| 8. | Have you ever been diagnosed as being HIV positive or having AIDS? | YES | NO |
| 9. | Have you ever had hepatitis or liver disease? | | |
| 10. | Have you ever had; asthma_____; any blood disorder_____; kidney disease_____; diabetes_____; joint pain/arthritis_____; tuberculosis_____; pneumonia_____; heart attack_____; heart disease or endocarditis_____: rheumatic fever_____; immune system disorders_____; other significant disease_____: If so, please specify:_____ | YES | NO |
| 11. | Do you take any medications, including birth control pills? | YES | NO |
| | Please specify name and purpose of medications:_____ | | |
| | _____ | | |
| | _____ | | |
| 12. | Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetaminophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other_____ | YES | NO |
| 13. | Do you require antibiotic pre-medication for a heart condition or artificial valve, etc.? | YES | NO |
| 14. | Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? | YES | NO |
| 15. | Have you ever used or are you now using tobacco or alcohol? | YES | NO |
| 16. | Is there any family history of substance abuse or misuse? | YES | NO |
| 17. | Is there any personal history of substance abuse or misuse? | YES | NO |
| 18. | Have you ever received counseling for use of alcohol and/or prescription drugs? | YES | NO |
| 19. | Do you take any sedative medication including herbal supplements? | YES | NO |
| 20. | Do you have any other allergies? <u>If Yes</u>, please describe:_____ | YES | NO |
| 21. | Have you ever had a nervous breakdown or undergone psychiatric treatment? | YES | NO |
| 22 | Women: Are you pregnant? | YES | NO |
| 23. | Are you now in pain? | YES | NO |
| 24. | How long ago did you last see a dentist? _____ | | |
| 25. | Who was your previous dentist?_____ | | |
| 26. | Do you think that your teeth are affecting your general health in any way? | YES | NO |
| 27. | Have you ever had any severe reaction to dental treatment or local anesthetics? | YES | NO |
| 28. | Are you allergic to any local anesthetic? | YES | NO |
| 29. | Do you have or have you ever had bleeding or sensitive gums? | YES | NO |
| | <u>If Yes</u>, have you seen your physician or cardiologist for a cardiac evaluation? | YES | NO |
| 30. | Have you ever taken Phen-Fen or similar appetite suppressants? | YES | NO |
| | <u>If yes</u>, have you seen your physician or cardiologist for a cardiac evaluation? | YES | NO |

**I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.**

**Signature**_____ **Date**_____

**(Patient, legal guardian or authorized agent of patient)**