PATIENT MEDICAL HISTORY

TODAY'S DATE:__________

Patients Name____ Date of Birth____________ Age_______

Physician's Name & Phone #:______________________________

Reason for Dental Appointment:____

Approximate date of last dental visit:______________________

Are you having pain or discomfort at this time?........ YES NO
Have you ever had a bad experience in the dental office?........ YES NO
Have you been under the care of a medical doctor during the past 2 years?........ YES NO
Have you ever been diagnosed with a heart murmur?........ YES NO
Have you ever been told by a Dr. that you need Antibiotics before dental procedures?........ YES NO – If YES please explain:__________________
Do you smoke or use tobacco?........ YES NO

Do you regularly take dietary supplements or herbal medicines?........ YES NO - If YES, do you regularly take any of the following?
____ Diet or Energy supplements ____Echinacea ____Garlic ____Ginger ____Ginkgo ____Ginseng ____Kava
____St. John's Wort ____Valerian ____Vitamin E > 400 IU ____Fish Oil > 3 grams/day

Are you concerned about the finances required to return your mouth to good dental health?... YES NO

Women Only:

Are you taking birth control pills?________ Are you Pregnant?________ If YES, # of weeks:__________ Are you Nursing? ________

Caution to women taking Birth Control Pills: Antibiotics prescribed while taking oral contraceptives may decrease contraceptive effectiveness. INITIAL & DATE ____________

List Medications you are currently taking:____

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma

Y	N	Conditions
☐	☐	HIV+ AIDS
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

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____
____

Do you have any disease, condition or problem NOT listed above?______________________ (for office use only): BP________

Consent: The undersigned hereby authorized Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform the treatment, prescribe medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk, which may include but are not limited to bruising, hematoma, cardiac stimulation, temporary or permanent numbness or muscle soreness. In rare instances, a needle can break and require surgical retrieval.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the Doctor at the next appointment without fail.

________ ______________________________ For:______________________ ______________________
date Signature of Patient, Parent or Guardian IF minor child or otherwise incapacitated Signature of Doctor