MEDICAL AND DENTAL HISTORY **NAME**_____ **BIRTHDATE**____/____/____ **TODAY'S DATE**____/___/____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker and/or Defibrillator
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes Type 1 or Type 2
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Osteoporosis

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Bananas
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Cocaine or other drugs
- ❑ Other:_____

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Have you been advised by your physician to pre-medicate prior to dental treatments? ☐ Yes ☐ No

Dental History: Check only if the answer is yes.

- ❑ Gums bleed while brushing or flossing
- ❑ Teeth sensitive to hot/cold liquids or foods
- ❑ Teeth sensitive to sour/sweet liquids or foods
- ❑ Pain in any of your teeth
- ❑ Sores or lumps in or near your mouth
- ❑ Have you had any head, neck or jaw injuries
- ❑ Any jaw joint clicking or pain
- ❑ Any difficulty opening or closing mouth
- ❑ Any difficulty chewing
- ❑ Frequent headaches
- ❑ Do you clench or grind your teeth?
- ❑ Do you bite your lips or cheeks often?
- ❑ Have you ever had any difficult extractions?
- ❑ Have you had any orthodontic work?
- ❑ Have you ever had prolonged bleeding following an extraction?
- ❑ Have you ever had instruction on the correct method of brushing and flossing your teeth?
- ❑ Have you ever had instruction on the care of your gums?
- ❑ Have you ever had any complications following dental treatment?

Please explain:_____

- Have you been admitted into a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician:_____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

*****Please list any medications, including non-prescription drugs, taken on a regular basis_____

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

_____ Date: _____
Print name of patient, parent or guardian Signature of patient, parent or guardian

For office use only: Reviewed by:_____ Date_____