*Medical History*

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications? If so, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **For Women:**Are you pregnant: \_\_\_\_\_\_\_ If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_ Are you nursing? **\_\_\_\_\_\_\_\_\_** |

Have you ever had any of the following diseases or medical conditions? If yes, please circle.

**Difficult Breathing**

**Heart Attack/Stoke**

**Emphysema/Glaucoma**

**Drug/Alcohol Abuse**

**High/Low Blood Pressure**

**Hemophilia**

**Abnormal Bleeding**

**Severe/Frequent Headaches**

**Congenital Heart Defect**

**Anemia/Radiation Treatment**

**Artificial Bones/Joints**

**Psychiatric Problems**

**Cancer/Chemotherapy**

**Diabetes/Tuberculosis**

**Rheumatic Fever**

**HIV+/aids**

**Epilepsy/Seizures/Fainting**

**Sinus Problems**

**Blood Transfusion**

**Heart Surgery/Pacemaker**

**Mitral Valve Prolapse**

**Kidney Problems**

**Artificial Valve**

**Asthma/Arthritis**

**Shingles**

**Difficulty Breathing**

**Hepatitis**

**Fever Blisters Venereal Disease**

**Heart Murmur Ulcers/Colitis**

Please list all other(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Dental History*

What would be the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently in pain? Y N Do you have pain in or near your ears? Y N**

**Sensitive to sweets? Y N Have you experienced any growth**

**Do your gums bleed? Y N or sore spots in your mouth? Y N**

**Do you chew on one side of your mouth? Y N Does any part of your mouth hurt**

**Do you habitually clench your jaw? Y N when clenched? Y N**

**Do you have or even had pain or Have you ever had Novocaine**

**discomfort in your jaw? (TMJ/TMD) Y N anesthetic? Y N**

**Prolonged Bleeding following extractions Any reactions or allergies to**

**In the past? Y N Novocaine? Y N**

**When was your last visit to a dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When was your last full mouth X-rays taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you allergic to any of the following?

Penicillin Tetracycline Latex Dental Anesthetics Erythromycin Aspirin Codeine

Others not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient if minor Date