Chart#:_____
FOR OFFICE USE ONLY

Medical History

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH (X)

_ Allergies to drugs
_ Allergies to anesthetics (Novacaine)
_ Any heart ailments
_ High blood pressure
_ Neurological problems
_ Radiation treatments
_ Excessive bleeding from cut or extractions
_ Anemia or blood problems
_ Arthritis
_ Fainting or dizzy spells
_ Asthma
_ Hay fever or Allergies in general
_ Diabetes
_ Kidney problems
_ Liver problems or hepatitis
_ Malignancies
_ Psychiatric care/ emotional problems
_ Rheumatic fever
_ Sinus problems
_ Epilepsy
_Stroke
_ Thyroid
_ Eye disorders
_Tonsillitis
_ Tuberculosis
_ Ulcer or colitis
_ Veneral disease
_ Prostate
_ Pregnancy
If so, what month _____
_ Hepatitis
_ Herpes
_ HIV Positive
_ Emphysema
_ Night sweats
_ Prolonged fever
_ Chronic diarrhea
_ Chronic fatigue
_ Sudden weight loss

Describe any current medical treatment, including drugs, impending operations, pregnancies or other information Dr. should be aware of:

_____

_____

_____

Are you taking drugs for: High blood pressure _____Cortisone or steroids _____ Blood thinners _____ Sedatives or tranquilizers _____

Other_____

Dental History

DATE OF LAST
DENTAL EXAM_____ ANY PREVIOUS MAJOR DENTAL TREATMENT [ ] Yes [ ] No When? _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWOING – INDICATE WITH (X)

_ Teeth sensitive to cold, heat, sweets or pressure
_ Bleeding gums. How long? _____
_ Food impaction
_ Clenching or grinding
_ Burning of tongue
_ Swelling or lumps in mouth
_ Frequent blisters on lips or mouth
_ Pain around ear
_ Unusual sounds in ear while eating
_ Bad breath
_ Unpleasant taste
_ Unfavorable dental experience
_ Complications from extractions
_ Periodontal treatment
_ Orthodontic treatment
_ Mouth breathing
_ Oral habits, i.e., fingernail biting cheek biting, etc.
_Cigarettes, pipe or cigar smoking
_ Texture of toothbrush
_ Frequency of brushing
_ Dental floss
_ Inter dental stimulators
_ Water jet device
_ Disclosing tablets or solution
_ Fluoride supplements

Signed:_____Date:_____

Patient – Parent or Guardian (if under 18)

Medical History Update

Date	Changes	Initial
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____