# DENTAL/MEDICAL HISTORY

Patient's Name: ____________________________________

Are you under a physician's care? ________ If so, for what?___________________________________

Physician's Name: ______________________ Phone number: _________________________________

Do you use tobacco? ______ Do you Clench or grind your teeth? ______

Do you have difficulty opening your mouth? ____ Have you had prolonged bleeding after extractions? _____

Do you need to premedication before any dental appointment? _____

If you are a woman, are you pregnant? _____

Please mark items below if you have or have had any of the following:

| | | |
|---|---|---|
| __ AIDS/HIV | __ Diabetes | __ Low Blood Pressure |
| __ Seasonal Allergies | __ Epilepsy/Seizures | __ Lung Disease |
| __ Alzheimer's | __ Excessive Bleeding | __ Mitral Valve Prolapse |
| __ Anemia | __ Fainting/Dizziness | __ Radiation Treatment |
| __ Angina | __ Frequent Headaches | __ Renal Dialysis |
| __ Arthritis/Gout | __ Glaucoma | __ Rheumatic Fever |
| __ Artificial Heart Valve | __ Heart Attack/Failure | __ Scarlet Fever |
| __ Artificial Joint | __ Heart Murmur | __ Shingles |
| __ Asthma | __ Pace Maker | __ Sickle Cell Disease |
| __ Blood Disease | __ Heart Trouble/Disease | __ Sinus Trouble |
| __ Breathing Problems | __ Hepatitis A | __ Stomach/Intestinal Disease |
| __ Bruise Easily | __ Hepatitis B or C | __ Stroke |
| __ Cancer | __ High Blood Pressure | __ Thyroid Disease |
| __ Chemotherapy | __ Irregular Heartbeat | __Tonsillitis |
| __ Chest Pains | __ Kidney Disease | __ Tuberculosis |
| __ Cold Sores/Fever Blisters | __ Leukemia | __ Ulcers |
| __ Congenital Heart Disease | __ Liver Disease | __ Other: __________________ |

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

| | | | |
|---|---|---|---|
| __ Aspirin | __ Barbiturates | __ Codeine | __ Erythromycin |
| __ Iodine | __ Latex | __ Local Anesthetics | __ Penicillin |
| __ Sedatives | __ Sulfa Drugs | __ Tetracycline | __ Other:_________ |
| __ Any Metals (Nickel, Mercury) | | | |

What medication are you currently taking: Please provide a separate list if possible

__________________________________________ __________________________________________

__________________________________________ __________________________________________

__________________________________________ __________________________________________

__________________________________________ __________________________________________

__________________________________________ __________________________________________

**Consent**:

The undersigned hereby authorizes Doctor to take x-rays, 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 any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient's signature: ______________________________________________ Date: ________________________