PATIENT

► **Patient Name:** _____ Date: _____

MEDICAL HISTORY

► **Primary Care Physician's Name:** _____ Date of last visit: _____

► **Have you ever experienced or been diagnosed with the following conditions?**

Anemia	☐	Epilepsy	☐	Shortness of breath	☐ Y
Anxiety/Nervousness	☐	Headaches	☐	Sinus trouble	☐ Y
Arthritis	☐	Heart murmur	☐	Stroke	☐ Y
Artificial heart valves	☐	Heart problems	☐	Swollen neck glands	☐ Y
Artificial joints	☐	Hepatitis Type _____	☐	Thyroid problems	☐ Y
Asthma	☐	Herpes	☐	Tuberculosis	☐ Y
Back problems	☐	High blood pressure	☐	Tumor or growth on head or neck	☐ Y
Bleeding with extractions or surgery	☐	HIV/AIDS	☐	Ulcer	☐ Y
Blood disease	☐	Jaundice	☐		
Cancer	☐	Jaw pain	☐	Women Only	
Chemotherapy	☐	Kidney disease	☐	Pregnant Due date_____	☐ Y
Cigarette, pipe, or cigar smoking	☐	Liver disease	☐	Nursing	☐ Y
Circulatory problems	☐	Low blood pressure	☐	Taking birth control pills?	☐ Y
Congenital heart lesions	☐	Mitral valve prolapse	☐		
Cortisone treatments	☐	Pacemaker	☐		
Cough, persistent or bloody	☐	Psychiatric treatment	☐	Major surgery or hospitalizations	☐ Y
Diabetes	☐	Radiation treatment	☐	_____	
Emphysema	☐	Respiratory disease	☐	_____	

► **List <u>all</u> medications you are currently taking and the correlating diagnosis:**

Med:_____ Dose:_____ Frequency:_____ For:_____

Med:_____ Dose:_____ Frequency:_____ For:_____

Med:_____ Dose:_____ Frequency:_____ For:_____

Med:_____ Dose:_____ Frequency:_____ For:_____

Pharmacy name: _____Phone (_____) _____

► **Indicate <u>all</u> of your allergies below:**

☐ Aspirin	☐ Iodine	☐ Penicillin
☐ Barbiturates (Valium/Xanax)	☐ Latex	☐ Sulfa Drugs
☐Opiates (Vicodin/Percocet)	☐ Local Anesthetics (Novocaine)	☐ Other _____

DENTAL HISTORY

Bleeding Gums Sensitivity Pain Loose Teeth Periodontal Disease Lumps/Sores Clenching/Grinding/TMJ Braces

Premedication before dental treatment Primary concern for today's visit:_____

ACKNOWLEDGEMENT

☐ I have had <u>no change</u> in my dental or medical history since my last visit.

☐ I attest that the dental and medical information above is current, complete, and accurate. I accept full responsibility for any information not updated or shared with the doctor.

Patient (or Guardian) Signature:_____ Date: _____/_____/_____