MEDICAL DENTAL HISTORY

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask.

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

Name _____ Occupation _____

Home Address _____ Employed By _____

City _____ Zip _____

Home TelephoneBusiness Telephone _____

Marital Status _____ Business Address _____

Social Security # _____ Age _____ Birth date _____ Sex _____

Parent or Spouse's Name _____ SS# _____

Parent or Spouse's Employer _____

Business Address _____

Yes	No		Yes	No	
☐	☐	Have you ever needed antibiotic coverage before a dental appointment?	☐	☐	Are you now taking or have you ever had radiation or chemotherapy for a disease?
☐	☐	Are you presently under the care of a physician?	☐	☐	Have you had a full mouth series of x-rays (18 film) or panoramic x-ray in the last 3 years?
☐	☐	Are you presently taking any drugs or medication if yes, list:	☐	☐	Have you had your wisdom teeth or 3rd molars extracted?
☐	☐	Are you allergic to any drugs? If yes, list:	☐	☐	Are you pregnant?

Do you have or have you had any of the following diseases or problems:

Yes	No		Yes	No	
☐	☐	Cardiovascular diseases?	☐	☐	Tuberculosis?
☐	☐	High blood pressure?	☐	☐	Stomach ulcers?
☐	☐	Low blood pressure?	☐	☐	Nervous condition?
☐	☐	Heart murmur?	☐	☐	Drug or alcohol dependency?
☐	☐	Rheumatic Fever?	☐	☐	Goiter or thyroid disorder?
☐	☐	Mitral valve collapse?	☐	☐	Convulsions or epilepsy?
☐	☐	Anemia or blood disorder?	☐	☐	Frequent nose bleeds?
☐	☐	Asthma or hay fever?	☐	☐	Sexually transmitted diseases?
☐	☐	Diabetes?	☐	☐	Artificial joints or valves?
☐	☐	Kidney trouble?	☐	☐	Prosthetic devices?
☐	☐	Jaundice or liver disease?	☐	☐	Periodontal or gum disease?
☐	☐	Hepatitis: If yes, what type? _____	☐	☐	Reaction to local anesthetic? (ie Novocaine)
		_____	☐	☐	Blood transfusion? When?
☐	☐	Blood transfusion? When? _____	☐	☐	Oral habits? (ie smoking, chewing tobacco,
☐	☐	AIDS or HIV positive?	☐	☐	thumb sucking, grinding)
☐	☐	Temporal Mandibular Disorder? (TMJ)			

Physician's name, address, and phone _____

Last visit to a dentist and type of treatment _____

Who can we thank for referring you? _____

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____