

America's Family Dental ★ DENTAL & MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If you answer yes to any of the following, please explain in the blank provided to the right. Thank you.

- Are you having a dental problem at this time? Yes No _____
- Are your teeth sensitive to hot, cold or biting pressure? Yes No _____
- Do you floss regularly? Yes No n/a _____
- Are you under a physician's care now? Yes No _____
- Have you ever been hospitalized or had a major operation? Yes No _____
- Have you ever had a serious head or neck injury? Yes No _____
- Are you taking any medications, pills, or drugs? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No Amount per day: _____
- Do you use controlled substances? Yes No _____

Women:		
Are you pregnant or trying to get pregnant?	<input type="radio"/> Yes <input type="radio"/> No	_____
Nursing?	<input type="radio"/> Yes <input type="radio"/> No	_____
Taking oral contraceptives?	<input type="radio"/> Yes <input type="radio"/> No	_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Local Anesthetics
- Other: _____

Please mark all that apply:

- | | | | | |
|--|---|---|---|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Chest Pains | <input type="radio"/> Frequent Headaches | <input type="radio"/> Kidney Problems | <input type="radio"/> Rheumatism |
| <input type="radio"/> Alzheimer's | <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Genital Herpes | <input type="radio"/> Leukemia | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Glaucoma | <input type="radio"/> Liver Disease | <input type="radio"/> Shingles |
| <input type="radio"/> Anemia | <input type="radio"/> Convulsions | <input type="radio"/> Gum Disease | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Angina | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Hay Fever | <input type="radio"/> Lung Disease | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Crowns / Bridges | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Dental Implants | <input type="radio"/> Heart Murmur | <input type="radio"/> Night Guard | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Dentures | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Orthodontics | <input type="radio"/> Stroke |
| <input type="radio"/> Asthma | <input type="radio"/> Diabetes | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Blood Disease | <input type="radio"/> Drug Addiction | <input type="radio"/> Hemophilia | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Easily Winded | <input type="radio"/> Hepatitis A | <input type="radio"/> Periodontal Scaling | <input type="radio"/> TMJ |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Emphysema | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Periodontal Surgery | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Herpes | <input type="radio"/> Psychiatric Care | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Bleaching | <input type="radio"/> Excessive Bleeding | <input type="radio"/> High Blood Pressure | <input type="radio"/> Radiation Treatments | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Bleeding Gums | <input type="radio"/> Excessive Thirst | <input type="radio"/> Hives or Rash | <input type="radio"/> Recent Weight Loss | <input type="radio"/> Ulcers |
| <input type="radio"/> Bonding/Veneers | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Hypoglycemia | <input type="radio"/> Renal Dialysis | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Frequent Cough | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Retainer | <input type="radio"/> Wisdom Teeth Extractions |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Jaw Pain/Popping/Clicking | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Yellow Jaundice |

Have you ever had any serious illness or dental concern no listed above? Yes No If yes, please explain: _____

Please rank the following in order from 1 to 4, that would prevent you from having dental treatment:

_____ Fear of Pain _____ Lack of Concern _____ Cost of Treatment _____ Missing Work Time

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. **It is my responsibility to inform the dental office of any changes in medical status and/or medications taken.**

Signature of Patient, Parent or Guardian

Date