MEDICAL-DENTAL HISTORY

NAME OF PATIENT:_____D.O.B.:_____

IN ORDER TORECEIVE TREATMENT ALL PATIENTS MUST COMPLETE A HEALTH HISTORY AND ANSWER ALL QUESTIONS. PLEASE BE ASSURED THE QUESTIONS ARE PERTINENT TO THE PROPER TREATMENT AND TO PROVIDE SAFETY FOR ANY HEALTH ISSUES. ALL ANSWERS WILL BE HELD IN THE STRICTEST OF CONFIDENCE BUT MUST BE ANSWERED HONESTLY AND ACCURATELY.IT MAY BE NECESSARY TO CONTACT YOUR PHYSICIAN IF WE HAVE ANY HEALTH CONCERNS, AND WE ASSURE YOU ANY INFORMATION RECEIVED WILL ALSO BE HELD IN CONFIDENCE. INCLUDED IN THIS FORM IS "PERMISSION TO RELEASE INFORMATION" FOR YOU TO SIGN.

1.NAME, ADDRESS, AND PHONE NUMBER OF YOUR FAMILY PHYSICAN._____

_____

2. DATE OF YOUR LAST DR. VISIT:_____ PURPOSE OF VISIT:_____

3. DO YOU HAVE ANY DRUG ALLERGIES?_____, IF YES TO WHAT MEDICATIONS:_____

4. DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR: RHEUMATIC FEVER,RHEUMATIC HEART DISEASE,HEART MURMUR,CONGENITAL HEART DISEASE,HEART TROUBLE, HEART ATTACK,ANGINA,HEART SURGERY, PACEMAKER,IRREGULAR HEART BEATS?_____ Circle any that apply

5. DO YOU HAVE ANY ARTIFICIAL JOINTS? _____ Hip or knee replacement

6. HAVE YOU EVER BEEN TOLD THAT YOU NEED TO PREMEDICATE FOR DENTAL TREATMENT?_____

7. DO YOU SUFFER FROM ANY DISABILITY?_____IF YES, DESCRIBE_____

8. HAVE YOU EVER OR ARE YOU NOW TAKING ANY ILLEGAL DRUGS?_____
This is being asked as drugs can interact and be dangerous to your health, some interactions can be fatal.

9. DO YOU HAVE AIDS OR ARE YOU HIV POSITIVE?_____IF YES, DESCRIBE AND PROVIDE CURRENT STATUS:_____

10. DO YOU NOW OR HAVE YOU EVER HAD VENEREAL DISEASE:_____ IF YES DESCRIBE:_____

11. DO YOU NOW HAVE OR HAVE YOU EVER HAD HEPATITIS?:_____IF YES DESCRIBE:_____

12. FOR FEMALES: ARE YOU PREGNANT?_____IF YES DUE DATE:_____ DO YOU TAKE BIRTH CONTROL PILLS?_____There are drugs that can render birth control pills ineffective.Information about the current use of medication is essential.

13. ARE YOU CURRENTLY TAKING ANY MEDICATIONS?_____ IF YES- LIST MEDICATIONS AND PURPOSE:_____

_____

14. HAVE YOU LOST WEIGHT RECENTLY?_____ IF YES DESCRIBE_____

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: CHECK ALL THAT APPLY:

STOMACH OR INTESTINAL DISEASE_____	ABNORMAL BLOOD PRESSURE_____
ASTHMA _____	BREATHING PROBLEMS_____
ANEMIA_____	HAY FEVER_____

EXCESSIVE BLEEDING_____
CANCER, RADIATION, OR CHEMOTHERAPY_____
KIDNEY PROBLEMS, RENAL DIALYSIS _____
ARTHRITIS OR RHEUMATISM _____
CONVULSIONS _____
HEAD INJURY _____
DO YOU SMOKE_____
TUBERCULOSIS _____
DIABETES _____
TUMOR OR GROWTHS _____
STROKE _____
FAINTING SPELLS _____
NECK INJURY _____
ARE YOU ON A SPECIAL DIET_____

15. HAVE YOU EVER HAD A MAJOR OPERATION:_____ IF SO FOR WHAT:_____
16. ARE THERE ANY OTHER HEALTH ISSUES YOU THINK WE SHOULD BE AWARE OF:_____

DENTAL HISTORY
DATE OF YOUR LAST DENTAL VISIT:_____ DO YOU HAVE X-RAYS OR DENTAL RECORDS:_____ REASON FOR LAST VISIT:_____

IN RESPECT TO YOUR PAST DENTAL TREATMENT:
1. HAVE YOU EVER FAINTED:_____ HAD ABNORMAL BLEEDING:_____
2. HAVE YOU EVER HAD AN ALLERGIC REACTIONS:_____
3. HAVE YOU EVER HAD ANY COMPLICATIONS FOLLOWING TREATMENT?_____
   IF YES, DESCRIBE:_____
4. DO YOUR GUMS BLEED ON BRUSHING OR WHEN EATING?_____
5. DO YOU GET FOOD CAUGHT BETWEEN YOUR TEETH?_____
6. HAVE YOUR TEETH SHIFTED,ARE THERE SPACES BETWEEN YOUR TEETH NOW THAT WERE NOT PREVIOUSLY THERE,OR DO YOUR TEETH SEEM LOOSE?_____
7. ARE ANY OF YOUR TEETH SENSITIVE TO HEAT OR COLD OR PRESSURE?_____
8. DO YOU GRIND YOUR TEETH OR CLENCH YOUR JAW?_____
9. DO YOU HAVE PAIN OR CLICKING IN YOUR JAW OR UP INTO YOUR EAR?_____
10. HAVE YOUR JAW MUSCLES EVER BEEN SORE?_____ IF YES, DESCRIBE_____
11. ARE THERE ANY SORES OR GROWTHS IN YOUR MOUTH?_____
12. DO ANY OF YOUR TEETH ACHE, OR ARE THERE ANY OTHER DENTAL COMPLAINTS?_____

NOTE; A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME.
TO THE BEST OF MY KNOWLEDGE THE PREVIOUS QUESTIONS HAVE BEEN ANSWERED ACCURATELY AND HONESTLY.

PERMISSION TO RELEASE HEALTH INFORMATION

I GRANT THE RIGHT TO THE DENTIST TO RELEASE HEALTH INFORMATION OBTAINED BY ME, AND INFORMATION ABOUT MY DNETAL TREATMENT TO THIRD PARTY PAYORS, AND/OR OTHER HEALTH PRACTICIONERS.

SIGNATURE OF PERSON COMPLETING THIS FORM:_____
PRINT NAME:_____DATE:_____
RELATIONSHIP IF NOT PATIENT:_____

HEALTH HISTORY UPDATED ON:_____
HEALTH HISTORY UPDATED ON:_____
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