MEDICAL/DENTAL HISTORY

Patient's name: _____

YES	NO	
☐	☐	Have you been under the care of a physician recently?
☐	☐	Have you ever had a serious illness?
☐	☐	Have you ever had any injury, surgery or x-ray therapy to the face or jaws?
☐	☐	Are you taking any medication at the present time?
☐	☐	Do you have heart disorders i.e. high blood pressure?
☐	☐	Do you have artificial heart valve or heart surgery?
☐	☐	Have you had a stroke?
☐	☐	Have you had a heart attack?
☐	☐	Have you ever had rheumatic heart disease?
☐	☐	Do you have heart murmur?
☐	☐	Do you have lung problems i.e. asthma, COPD, shortness of breath, or persistent cough?
☐	☐	Do you have thyroid problems?
☐	☐	Do you have diabetes?
☐	☐	Do you have GI problems?
☐	☐	Do you have ulcers?
☐	☐	Do you have liver problems?
☐	☐	Do you have kidney problems?
☐	☐	Do you have artifical joints or joint replacement?
☐	☐	Do you have blood disorders?
☐	☐	Do you have history of any contagious disease i.e. HIV, hepatitis, or TB?
☐	☐	Do you or have you had cancer?
☐	☐	Do you have history of chemo therapy, radio therapy or surgery?
☐	☐	Do you have psychological disorders?

☐ ☐ Do you have any other allergies or adverse reactions? Circle any allergies you have:

[ ] Penicillin [ ] Clindamycin [ ] Latex [ ] Advil (NSAIDS) [ ] Tylenol [ ] Lidocaine

[ ] Ultracaine [ ] Metals [ ] Ativan [ ] Other reactions to substances not listed above

☐ ☐ Do you smoke?

☐ ☐ Do you consume alcohol?

☐ ☐ Women – Are you pregnant? Are you taking any oral contraceptives?

☐ ☐ Do you have a history of TMD?

☐ ☐ Do you have a history of tooth loss of periodontal disease?

☐ ☐ When was your last check up and cleaning? _____

☐ ☐ Do you object to dental xrays?

☐ ☐ Do you have any dental concerns? _____