Patient Medical & Dental History

1. Are you having pain or discomfort at this time?..... Yes No
2. Have you ever been hospitalized?..... Yes No
   Please list any surgeries and dates_____
3. Have you been a recipient of any artificial organs, joints or valves?..... Yes No
4. **Have you been told you need to premedicate for dental appointments?**..... Yes No
5. Have you been under the care of a medical doctor during the past 2 years?..... Yes No
   Physicians Name_____
   Phone#_____
6. Have you taken any medication or drugs during the past two years?..... Yes No
7. Are you presently taking any medication? If so list medication & Reason..... Yes No

_____

_____

8. Are you aware of being allergic to or have you ever reacted adversely to any medications? Yes No
   If yes please list:_____

_____

9. Please indicate by a check which of the following you have had or have at present.

☐ Heart Failure	☐ Stroke	☐ Hepatitis A (infectious)	☐ Rheumatism
☐ Heart Disease or attack	☐ Artificial Joints	☐ Hepatitis B (serum)	☐ Pain in Jaw Joints
☐ Angina Pectoris	☐ Ulcers	☐ Venereal Disease	☐ Cortisone Medication
☐ Congenital Heart Disease	☐ Diabetes	☐ A.I.D.S.	☐ Drug Addiction
☐ Heart Murmur	☐ Kidney Trouble	☐ H.I.V. Positive	☐ Allergies or Hives
☐ High Blood Pressure	☐ Thyroid Problems	☐ Cold Sores/Fever Blisters	☐ Sinus Trouble
☐ Arteriosclerosis	☐ Glaucoma	☐ Blood Transfusion	☐ Radiation Therapy
☐ Mitral Valve Prolapse	☐ Cosmetic Surgery	☐ Hemophilia	☐ Chemotherapy
☐ Artificial Heart Valve	☐ Emphysema	☐ Anemia	☐ Epilepsy or seizures
☐ Heart Pacemaker	☐ Chronic Cough	☐ Sickle Cell Anemia	☐ Fainting/ Dizzy Spells
☐ Heart Surgery	☐ Tuberculosis	☐ Bruise Easily	☐ Nervousness
☐ Rheumatic Fever	☐ Asthma	☐ Liver Disease	☐ Psychiatric Treatment
☐ Arthritis	☐ Hay Fever	☐ Yellow Jaundice	

10. Do you smoke?..... Yes No
    How many years?_____ Packs per day_____
11. Do you drink alcoholic beverages?..... Yes No
12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... Yes No
13. Do your ankles swell during the day?..... Yes No
14. Have you lost or gained more than 10 pounds in the last 3 months?..... Yes No
15. Has your medical doctor ever said you have cancer or a tumor?..... Yes No
16. Do you have or have you had any disease, condition, or problem not listed?..... Yes No
    If yes please list:_____

For Women Only:

Are you pregnant?☐Yes, what month?_____ ☐No Are you nursing?☐Yes ☐No
Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____ **Date**_____

Patient Print Name _____