PATIENT MEDICAL HISTORY

Please Print Legibly

First Name:	Last Name:	M.I.	Gender: M / F
Home Phone ( )	Cell Phone ( )	Work Phone: ( )	
Social Security Number (ONLY if using insurance):		Date of Birth / /	
Home Address	City/State/Zip		
Employer Name	Occupation		
Employer Address	Guarantor (when patient is under parent policy)		
Referring Dentist	Family Dentist		
DENTAL Insurance Company/s	**DENTAL** Insurance Address/Phone Number		
Subscriber's Name	Subscriber's Social Security Number		
Subscriber's DOB / /	Group #	Relationship	

	YES	NO	DON'T KNOW
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.			
2. Has there been any change in your general health within the past year? If yes, please explain.			
3. Are you under the care of a physician for a current problem? If yes, explain.			
4. Have you been hospitalized within the past 5 years? Please specify.			
5. Please list any medications or drugs you are currently taking:			
6. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
7. Have you ever had any ALLERGIC or ADVERSE REACTIONS to Anesthetics, Antibiotics, Medications OR Household Bleach? If so, what?			
8. Is there any condition concerning your health that the doctor should be told?			
9. Do you wish to speak to the doctor privately about anything?			
10. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
11. Have you ever required a blood transfusion?			
12. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?			
13. Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
14. Are you required to take antibiotics prior to dental treatment due to Heart Condition, Prosthetics, or other medical condition?			
15. Women only: are you pregnant, nursing or on birth control pills?			
16. Have you ever taken a bisphosphonate such as Boniva? If so, have you stopped? When?			
17. Are you taking any herbal medicine (i.e., St. John's Wort)?			
18. Have you ever taken the "fen-phen" diet?			

19. Do you have or have you had any of the following?

- [ ] High blood pressure
- [ ] Heart murmur or prolapsed valve
- [ ] Joint prosthesis (hip, knee, etc.)
- [ ] Rheumatic fever or rheumatic heart disease
- [ ] Congenital heart disease
- [ ] Cardiovascular disease: heart attack, stroke or bypass
- [ ] Prosthetic heart valve
- [ ] Blood disorder (e.g. anemia)
- [ ] Venereal disease
- [ ] Asthma
- [ ] Allergy to latex
- [ ] Low blood pressure
- [ ] Chest pain, angina
- [ ] Swollen ankles, arthritis or joint disease
- [ ] Cardiac pacemaker
- [ ] Heart surgery
- [ ] Delay in healing
- [ ] Tuberculosis
- [ ] Emphysema
- [ ] X-Ray treatment or chemotherapy
- [ ] On a diet
- [ ] History of alcohol abuse
- [ ] Eye disease or glaucoma
- [ ] Infectious mononucleosis
- [ ] Sinus trouble
- [ ] Thyroid problems
- [ ] Diabetes
- [ ] Stomach ulcers, colitis
- [ ] Hepatitis, jaundice, liver disease
- [ ] Psychiatric treatment
- [ ] Fainting spells or seizures
- [ ] Epilepsy
- [ ] Cancer
- [ ] Temporomandibular joint problems (TMJ)
- [ ] Low blood sugar
- [ ] Dialysis
- [ ] Irregular heart beat
- [ ] Contagious diseases
- [ ] Bronchitis, chronic cough
- [ ] Hay fever or sinus problems
- [ ] Problems with the immune system
- [ ] Difficult breathing or other lung trouble
- [ ] Chronic fatigue or night sweats
- [ ] History of drug abuse
- [ ] Wear contact lenses
- [ ] Bruise easily
- [ ] Gallbladder trouble
- [ ] None of the above

20. Do you have any disease, condition or problem not listed above? Specify.

Emergency Contact:

Name:	Phone Number:	Relation:

Women only:

Possibility of pregnancy:	YES / NO	Nursing:	YES / NO
Estimated delivery date:		Taking birth control pills*:	YES / NO

***NOTE:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional methods of control.

Injury:

This visit is related to an accident	YES / NO	Work related:	YES / NO
Date of injury:			
Insurance company handling the claim:			
Claim Number:			

______________________________ ____________________

Patient Signature (Parent signature if patient is under 18 years of age). Date