Medical History

Name:____ Date: ______________________

Check if you have had any of the following:

☐ High Blood Pressure: If checked, please write your last BP reading:______________________

What medication(s) are you taking to control this? ______________________________________

Has your doctor ever recommended that you be pre-medicated with an antibiotic before a dental appointment? ☐ Yes ☐ No

If yes, please explain: ____

If you have forgotten to take your pre-med, please tell us now!!

☐HEART

☐Artificial Heart Valve
☐Heart Disease
☐Mitral Valve Prolapse
☐Rheumatic Fever
☐Heart Murmur
☐Low Blood Pressure
☐Other Heart Problems:

OTHER:

☐Stroke
☐Kidney Disease
☐Liver Disease
☐Mental Disorder
☐Nervous Disorder
☐Fainting/Dizziness
☐Smokeless/Dip

☐Hepatitis
☐HIV/AIDS
☐Herpes/Fever Blisters
☐Arthritis
☐Alcohol Use
☐Tobacco Use
Packs/Day: ____________

☐ALLERGIES

☐Allergies to Penicillin
☐Allergies to Latex
☐Allergies to Sulfa
☐Allergies to Codeine
☐Other:______________________

☐CANCER

Type____________________
When:___________________
☐Chemotherapy
☐Radiation Treatment

☐Are you taking blood thinners?
Name of Drug __________________
☐Osteoporosis
☐Diabetes

Please list all other medical conditions not shown above: ___________________________________

____

Please list **all medications** that you are currently taking, **including vitamins and herbs**: ________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Physician's Name: ___________________________________ Date of Last Visit: ___________________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please explain:____________________

____

(Women) Are you pregnant or nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No

Dental History

Check if you have had problems with any of the following:

☐Bad Breath
☐Bleeding Gums
☐Clicking or popping jaw
☐Food collecting between teeth

☐Grinding Teeth
☐Loose or broken teeth
☐Periodontal treatment

☐Sensitivity to hot/cold (circle)
☐Sensitivity to sweets
☐Sensitivity when biting
☐Sores/growths in your mouth

How often do you brush?____________________________ Floss? ______________________________

Reason for today's visit?______________________________________ Date of last DDS visit: ____________

Former Dentist:___________________________________ Phone: _______________________________