

PATIENT

► Your Name (Patient's Name): _____ Date of last visit: _____

DENTAL & MEDICAL HISTORY

► Physician's Name: _____ Date of last visit: _____

► Have you ever been diagnosed with or experienced the following conditions?

- | | | | | | |
|---|---|-----------------------|---|-----------------------------------|---|
| AIDS/HIV | <input type="checkbox"/> Y <input type="checkbox"/> N | Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N | Shortness of breath | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus trouble | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N | Skin rash | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Special diet | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis Type _____ | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N | Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N | Swollen feet or ankles | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N | High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N | Swollen neck glands | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bleeding abnormally, with
extractions or surgery | <input type="checkbox"/> Y <input type="checkbox"/> N | Jaundice | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N | Tonsillitis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Tumor or growth on head or neck | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Y <input type="checkbox"/> N | Low blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N | Ulcer | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N | Venereal disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Congenital heart lesions | <input type="checkbox"/> Y <input type="checkbox"/> N | Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Weight loss, unexplained | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N | Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N | Major surgery? _____ | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cough, persistent or bloody | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N | Hospitalized for? _____ | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N | Do you wear contact lenses? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N | Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Take any non-prescribed drugs? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N | Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N | If yes, what and how often? _____ | |

► Do you have any other dental or medical condition(s) that could affect your dental treatment? If so, please describe below:

WOMEN ONLY Pregnant? Due date _____ Y N Taking birth control pills? Y N Are you nursing? Y N

► Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). _____ Yes _____ No

► List all medications you are currently taking and the correlating diagnosis: ► Indicate all of your allergies below:

- | | | | |
|--|---------------------------------------|---------------------------------|-------------------------------------|
| Med: _____ Dose: _____ Frequency: _____ For: _____ | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin |
| Med: _____ Dose: _____ Frequency: _____ For: _____ | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| Med: _____ Dose: _____ Frequency: _____ For: _____ | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local | <input type="checkbox"/> Other |
| Med: _____ Dose: _____ Frequency: _____ For: _____ | | anesthetic | _____ |
- Pharmacy name: _____ Phone (_____) _____

ACKNOWLEDGEMENT

► Check ONE box and acknowledge with your signature below:

- I have had no change in my dental or medical history since my last visit.
- I attest that the dental and medical information above is current, complete, true, and accurate. I accept full responsibility for any information not updated or shared with the doctor.

Patient (or Guardian) Signature: _____ Date: ____/____/____

Name (if signing for minor): _____