MEDICAL/DENTAL HISTORY

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Name _____ Birth date _____

Physician _____ Physician Phone _____

MEDICAL CONDITIONS – Please check any of the following that you have or have had.

☐ ALLERGIES	☐ DIABETES	☐ HEART PROBLEMS	☐ **PENICILLIN ALLERGY**
☐ ALZHEIMERS	☐ DIZZINESS	☐ HEPATITIS	☐ PREGNANCY
☐ **AMOXICILLIN ALLERGY**	☐ DOWN SYNDROME	☐ HIGH BLOOD PRESSURE	☐ RADIATION TREATMENT
☐ ANEMIA	☐ EPILEPSY	☐ HIV	☐ RHEUMATISM
☐ ARTHRITIS	☐ **ERYTHOMYCIN ALLERGY**	☐ **IBUPROFEN ALLERGY**	☐ SINUS PROBLEMS
☐ ARTIFICIAL JOINTS	☐ EXCESSIVE BLEEDING	☐ JAUNDICE	☐ STOMACH PROBLEMS
☐ ASPIRIN ALLERGY	☐ FAINTING	☐ KIDNEY DISEASE	☐ STROKE
☐ BEHCET'S DISEASE	☐ GLAND DISORDER	☐ LIVER DISEASE	☐ **SULFA ALLERGY**
☐ BLOOD DISORDER	☐ GLAUCOMA	☐ LOW BLOOD PRESSURE	☐ TUBERCULOSIS
☐ CANCER	☐ GOUT	☐ MENTAL DISORDER	☐ TUMORS
☐ **CECLOR ALLERGY**	☐ HAY FEVER	☐ NERVOUS DISORDER	☐ ULCERS
☐ **CODEINE ALLERGY**	☐ HEAD INJURIES	☐ PACEMAKER	☐ VENEREAL DISEASE
☐ CROHN'S DISEASE	☐ HEART MURMUR	☐ PARKINSONS	

☐ OTHER ALLERGIES/CONDITIONS _____

MEDICAL QUESTIONNAIRE – Please answer yes or no.

Are you currently under any medical treatment? _____ Do you have difficulty breathing when lying down? _____
Do you bruise easily? _____ Do your wounds heal slowly or bleed for a prolonged time? _____
Have you ever had radiation therapy? _____ Have you ever had a major operation? _____
Have you ever had a bad response to a drug? _____ Are you presently in good health? _____
Women are you pregnant? _____ Trimester _____
Do you smoke? _____ If so, how much? _____

MEDICATIONS – Please check any medication you are taking, and **include dosages and frequency**

☐ ANALGESIC _____ ☐ BLOOD PRESSURE MED _____ ☐ TOPICAL SKIN MED _____
☐ ANTIBIOTICS _____ ☐ BLOOD THINNERS _____ ☐ TRANQUILIZERS _____
☐ ANTIHISTAMINE _____ ☐ DIET PILLS _____ ☐ VALIUM _____
☐ BIRTH CONTROL _____ ☐ HEART MED _____ ☐ VITAMINS _____
☐ OTHER _____

DENTAL QUESTIONNAIRE – Please check all that apply

☐ BRACES ☐ GUM DISEASE TREATMENT ☐ TOOTH EXTRACTION ☐ OTHER DENTAL SURGERY

How often do you brush your teeth? _____ Floss _____
When was a complete series of x-rays taken? _____ When was your last dental exam? _____
Are you experiencing any discomfort or sensitivity in your mouth? _____ Do you have a habit of grinding or clenching your teeth? _____
Do you ever hear a clicking or popping noise when you chew? _____ Do your gums bleed? _____ When? _____

SIGNATURE _____ **DATE** _____

FORM UPDATE

DATE _____ PATIENT'S INITIALS _____ REMARKS _____

DATE _____ PATIENT'S INITIALS _____ REMARKS _____

DATE _____ PATIENT'S INITIALS _____ REMARKS _____