MEDICAL/DENTAL HEALTH HISTORY

Patient Name_____ Date of Birth _____

(Please check those you currently have or have had in the past)

__ AIDS
__ Allergies
__ Anemia
__ Arthritis
__ Artificial Joint or Valve
__ Asthma
__ Blood Disease
__ Bruise Easily
__ Cancer
__ Cold Sores/Fever Blisters
__ Diabetes
__ Diet (Special/Restricted)
__ Dizziness
__ Emphysema
__ Epilepsy, seizures, or fainting spells
__ Glaucoma
__ HIV Positive
__ Headaches Migraine/Frequent
__ Heart (Attack, Disease, Surgery)
__ Heart Murmur
__ Hepatitis
__ High Blood Pressure
__ Jaundice
__ Kidney Disease
__ Liver Disease
__ Low Blood Pressure
__ Mitral Valve Prolapse
__ Nervous Disorders
__ Pacemaker
__ Radiation Treatment
__ Respiratory Problems
__ Rheumatic Fever
__ Sexually Transmitted Disease
__ Sinus Problems
__ Stomach Problems
__ Stroke
__Thyroid Problems
__ Tuberculosis
__ Ulcer
__ Other _____

Are you allergic to, or have you reacted adversely to any of the following?

__ Latex materials
__ Penicillin or other antibiotics
__ Local anesthetics ("Novocain")
__ Codeine or other narcotics
__ Sulfa drugs
__ Barbiturates, sedatives, or sleeping pills
__ Aspirin
__ Other:_____

Are you taking any of the following? (check and list name)

__ Aspirin
__ Anticoagulants (blood thinners)_____
__ Antibiotics or sulfa drugs_____
__ High blood pressure medicine_____
__ Antidepressants or tranquilizers_____
__ Insulin, Orinase, or other diabetes drug_____
__ Nitroglycerin
__ Cortisone or other steroids_____
__ Osteoporosis (bone density) medicine_____
__ Other Medications (please list)_____

Do you smoke or use chewing tobacco? __ Yes __ No
Do you use controlled substances? __ Yes __ No
Are you currently under medical treatment? __ Yes __ No
(If yes, please explain)_____
_____

Women:

__ I am pregnant Expected Due Date _____
__ Could possibly be pregnant

Do your gums bleed while brushing or flossing? __ Yes __ No
Are your teeth sensitive to sweet or sour liquids/food? __ Yes __ No
Do you have any sores or lumps in or near your mouth? __ Yes __ No

Have you ever experienced any of the following problems with your jaw?
Clicking __ Yes __ No
Pain (Joint, Ear, Side of Face?) __ Yes __ No
Difficulty in opening or closing? __ Yes __ No
Difficulty in chewing? __ Yes __ No

Are your teeth sensitive to hot or cold liquids/food? __Y __N
Do you feel pain to any of your teeth? __Y __N
Have you had any head, neck, or jaw injuries? __Y __N
Do you clench or grind your teeth? __Y __N
Have you had any difficult extractions in the past? __Y __N
Prolonged bleeding following extractions? __Y __N
Do you wear dentures or partials? __Y __N
if yes, approximatedate of placement:_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. I authorize Dr. K Family Dentistry to release any information including the diagnosis and record of any treatment or examination rendered to me or my child to third party payors and/or health practitioners.

Signature of Patient (or parent if under 18)_____ Date _____