Time 8:29 AM

Dale Family Dentistry

Date 3/31/2017

Current Medical History 2016

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following:

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Are you taking any prescription medications?	○ Yes ○ No	If yes
Do you smoke, chew, use snuff or other tobacco?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergies? ○ Yes ○ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Anemia	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Asthma	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Bruise Easily	○ Yes ○ No
Cancer	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Cold Sores/Fever Blister	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No
Diabetes	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Emphysema	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
Frequent Headaches	○ Yes ○ No	Glaucoma	○ Yes ○ No	Hay Fever	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Heart Surgery	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Hemophilia	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Liver Disease	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No
Psychiatric Care	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Stroke	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Ulcers	○ Yes ○ No

Have you had any serious illness not listed above? ○ Yes ○ No If yes

Do your gums bleed while brushing or flossing?	○ Yes ○ No
Are your teeth sensitive to hot or cold liquids/foods?	○ Yes ○ No
Are your teeth sensitive to sweet or sour liquids/foods?	○ Yes ○ No
Do you feel pain in any of your teeth?	○ Yes ○ No
Do you have any clicking, pain or difficulty opening or closing your jaw?	○ Yes ○ No
Do you clinch or grind your teeth?	○ Yes ○ No
Have you had any periodontal (gum) treatments?	○ Yes ○ No
Are you interested in improving the appearance of your teeth?	○ Yes ○ No
Are you apprehensive about dental treatment?	○ Yes ○ No

Comments (include Physician's name and phone number):

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____