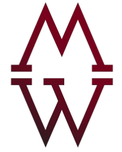

MEDICAL/DENTAL HISTORY

Name: ______________________________ Physician: ______________________________

Medical Health History: Although dental personnel primarily treat the areas in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. We thank you for answering the following questions as completely as possible.

Are you allergic to any of the following? (Circle if applicable)

Aspirin, Penicillin, Codeine, Acrylic, Metals, Latex, Local Anesthetics, other:

Do you have, or have you had, any of the following? (Circle if applicable)

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer
Chemotherapy
Cold Sores
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy/Seizures
Excessive Bleeding
Excessive Thirst
Fainting/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problem
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatment
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors/Growth
Ulcers
Venereal Disease
Yellow Jaundice

DENTISTRY
& ESTHETICS

MEDICAL/DENTAL HISTORY

Do you have any other condition not listed above? Yes / No

If yes, please explain: ______________________________

Have you ever been hospitalized? Yes / No

Are you currently taking any prescription medications, over-the-counter medications, or vitamins/supplements? Yes / No

Please list name, dosage, and how often you take each medication: ______________________________

____

____

WOMEN: Are you pregnant or trying to become pregnant? Yes / No Nursing? Yes / No

Are you taking birth control pills? Yes / No

DENTAL HEALTH HISTORY

Please circle any of the following that apply to you:

Clicking/popping in jaw joint
Pain in jaw joint
Clenching/grinding
Bad breath
Bleeding gums
Loose/broken teeth

Sensitivity in teeth
Food collection between teeth
Canker sores
Fever blisters
Previous injury of mouth/jaws
Previous surgery in mouth

Have you ever had a reaction to local anesthetic? Yes / No

Have you ever had complications following dental treatment? Yes / No

Do you smoke or use tobacco products? Yes / No

Are you nervous/concerned about having dental work? Yes / No

Is there a specific treatment you are interested in having done? Yes / No

If yes, please explain: ______________________________

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 the patient's) health, and that it is my responsibility to inform MW Dentistry of any changes in medical status.

Signature of patient, parent, or guardian ______________________ Date ______________