Art of The smiles

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PATIENT MEDICAL HISTORY

Your comfort and good dental health are dependent upon an accurate knowledge of your medical well-being. Many medical situations can affect, or be affected by, procedures or drugs used for dentistry. Therefore, please fill out the following carefully. THANK YOU.

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? Please ✓ if yes.

- Tonsillitis ☐
- Jaundice ☐
- Hepatitis ☐
- Scarlet Fever ☐
- Rheumatic Fever ☐
- Diabetes ☐
- Thyroid Condition ☐
- Malignancies ☐
- Glaucoma ☐
- Chronic Sinus Problem ☐
- Fainting or Dizziness ☐
- Heart Attack ☐
- Stroke ☐
- High Blood Pressure ☐
- Low Blood Pressure ☐
- Stomach Ulcer ☐
- Alcoholism ☐
- Epilepsy ☐
- Emotional Concerns/ Psychiatric Care ☐
- Kidney Disease ☐
- Asthma ☐
- Bleeding or Blood Problem ☐
- Herpes Simplex I (canker sores that are troublesome) ☐
- Herpes Simplex II (genital herpes) ☐
- AIDS or AIDS Relatex Complex ☐
- Venereal Disease (new or in last 24 months) ☐

	YES	NO
HAVE YOU EXPERIENCED AN UNUSUAL REACTION TO ANY OF THE FOLLOWING: Penicillin, Codeine, Aspirin	☐	☐
HAVE YOU EVER BEEN TOLD BY YOUR DOCTOR THAT YOU HAVE A HEART MURMUR or any heart conditions such as mitral valve prolapse, irregular heartbeat, etc	☐	☐
HAVE YOU HAD ANY PROSTHETIC SURGERY SUCH AS AN ARTIFICIAL HEART VALVE replacement or an artificial hip or joint replacement?	☐	☐
ARE YOU UNDER ANY MEDICAL TREATMENT NOW?	☐	☐

IF YOU HAVE MARKED ANY OF THE ABOVE WITH A YES, PLEASE GIVE US A BRIEF HISTORY ON THE FOLLOWING LINES.

_____

_____

Your physician:

Name: _____

City: _____

If you see a specialist:

Name: _____

City: _____

Women:

	YES	NO
Are you pregnant?	☐	☐
Are you taking hormone medication?	☐	☐
Are you taking birth control medication?	☐	☐
Are you taking fertility medication?	☐	☐

DENTAL HISTORY

HOW LONG HAS IT BEEN SINCE YOUR LAST DENTAL CLEANING? _____

FOR WHAT WERE YOU LAST SEEN BY A DENTIST? _____

HAVE YOU EVER EXPERIENCED AN UNUSUAL REACTION TO DENTAL ANESTHETICS (Novocaine-Carbocaine)? _____

DO YOU HAVE ANY SIGNIFICANT FEAR OR APPREHENSION OF DENTAL TREATMENT? _____

HAVE YOU HAD IN THE PAST, OR DO YOU HAVE NOW? Please ✓ if yes.

Teeth sensitive to:
- cold ☐
- heat ☐
- pressure ☐
- sweets ☐

- Swelling or lumps in mouth ☐
- Frequent cold sores or blisters in mouth ☐
- Pain upon chewing ☐
- Pain in your ear or joint ☐
- Periodontal (gum) treatment ☐
- Root Canal ☐
- Orthodontic treatment ☐

Notes: _____

_____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Name (printed) _____ Date _____

Signature _____