NEW/CURRENT PATIENT MEDICAL / DENTAL HISTORY(Copy) 2(Copy)

Patient Name: Birth Date: Date Created:

DENTAL HISTORY (NEW PATIENT'S ONLY)

Do you know the date of your last dental appointment? If yes, please give/estimate date.	◯ Yes ◯ No	If yes
Do you know the date of your most recent dental x-rays (estimate if not known)?	◯ Yes ◯ No	If yes
Did you have a previous dentist? If yes, please list his/her name and phone number.	◯ Yes ◯ No	If yes
Do you have a specific dental issue that you wish us to treat today? If yes, please list it.	◯ Yes ◯ No	If yes

MEDICAL HISTORY (ALL PATIENTS)

Primary Care Physician's name and phone number please. If none list as "NONE".	◯ Yes ◯ No	If yes
Emrgency Contact person. Name, phone number and relationship please.	◯ Yes ◯ No	If yes
The date of your most recent physical exam please. If none list as "NONE".	◯ Yes ◯ No	If yes

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES?

AIDS / HIV	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Artifical Joint	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
Fainting Spells or Dizziness	◯ Yes ◯ No	Heart Attack	◯ Yes ◯ No	Heart Murmer	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No
Herpes	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Kidney disease	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Mouth Ulcers	◯ Yes ◯ No

Have you ever had any other illness or medical issue not listed? If yes, please list.	◯ Yes ◯ No	If yes
WOMEN - ARE YOU PREGNANT?	◯ Yes ◯ No	

MEDICATIONS

Do you take any prescribed medications including daily aspirin? If yes, please list them.	◯ Yes ◯ No	If yes
Did you take any medications today? If yes, please list them.	◯ Yes ◯ No	If yes
Do you need to be premedicated for your dental work? If yes, the reason and medication.	◯ Yes ◯ No	If yes

ALLERGIES

Are you allergic to any of the following?

Aspirin	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No	Codeine	◯ Yes ◯ No
Acrylics	◯ Yes ◯ No	Metals	◯ Yes ◯ No	Latex	◯ Yes ◯ No
Sulfa Drugs	◯ Yes ◯ No	Local Anesthetics	◯ Yes ◯ No		

Are you allergic to anything not listed above? If yes, please list.	◯ Yes ◯ No	If yes

SIGNATURE

Signature of Patient, Parent or Guardian:

X _____ Date:_____