TODAY'S DATE: _____

MEDICAL HISTORY

Patient's Name:_____ Sex:____ Age ____ DOB:_____
LAST FIRST MI

Spouse's Name:_____ Spouse's Phone: _____

Closest Relative:_____ Relative's Phone: _____

Your Physician: _____ Physician's Phone: _____

Your Pharmacy: _____ Pharmacy Phone: _____

□ Y □ N Are you in good health?
□ Y □ N Has your health changed since last year?
□ Y □ N Are you under the care of a physician?

Date of last physical exam? _____

MEDICAL CONDITIONS:

_____
_____
_____

DRUG ALLERGIES:

_____
_____
_____

CURRENT MEDICATIONS:

_____
_____
_____
_____

HOSPITALIZATION OR SURGERY:

_____
_____
_____

SPECIAL PRECAUTIONS:

During dental treatment bacteria from your mouth can enter the bloodstream and lodge in your heart. This is a risk for some people with cardiac abnormalities. If you have any of these conditions you may be required to take antibiotic medication before dental treatment.

CHECK ALL THAT APPLY:

☐ Heart attack? Date:
☐ Heart surgery or pacemaker? Date:
☐ Mitral valve prolapse?
☐ Heart murmur or irregular heartbeat?
☐ History of Rheumatic Fever?
☐ Heart defect from birth?
☐ Angina (chest pain)?
☐ Taking heart medications or anticoagulants?
☐ Prosthetic replacement (heart valve, hip, knee, etc)?
☐ Vascular surgery (repair an artery)?
☐ History of Lupus (autoimmune disease)?
☐ Any blood transfusions? Date:

CHECK ALL MEDICAL HISTORY ITEMS THAT APPLY:

☐ High blood pressure	☐ Allergies / Hay fever	☐ Frequent infections
☐ Coronary artery disease	☐ T.B. / Asthma	☐ Hepatitis
☐ Congestive heart failure	☐ Bronchitis / Pneumonia	☐ Anemia
☐ Peripheral vascular disease	☐ Ulcer / GI disorder	☐ Arthritis
☐ Shortness of breath	☐ Liver disease	☐ Osteoporosis
☐ Heart murmur	☐ Kidney disease	☐ Nervousness
☐ Chest pain	☐ Diabetes	☐ Scarlet fever
☐ Stroke	☐ Immuno depressed disease	☐ Rheumatic fever
☐ Dizziness / Fainting	☐ Venereal disease	☐ Other _____

Please Continue On The Back Side

DENTAL HISTORY

What is your chief dental concern? Please describe: _____

_____

If you could change anything about your smile … what would it be? Please describe: _____

_____

Check Any Problems You Experience:

- ☐ Pain in your teeth or gums?
- ☐ Clicking noise in you jaw joint?
- ☐ Pain in your jaw or jaw joint?
- ☐ Clenching or grinding your teeth?
- ☐ Chronic pain in your head or neck?
- ☐ Recurring headache or neck ache?
- ☐ Sores or ulcers on your lips or inside your mouth?
- ☐ Fever blisters?
- ☐ Swelling on your face or in your mouth?
- ☐ Sensitivity to hot, cold or sweets?
- ☐ Bleeding gums when brushing or flossing?
- ☐ Prolonged bleeding after an injury?
- ☐ Loose teeth when chewing?
- ☐ Food lodging between your teeth?
- ☐ Stained or discolored teeth?
- ☐ Persistent bad breath?
- ☐ Allergic to latex products (gloves)?

For Women Only:

If you are using oral contraceptives it is important that you know that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use alternative methods of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant! Check all that apply below:

- ☐ Are you pregnant or nursing? For how long? ____
- ☐ Are you trying to become pregnant?
- ☐ Do you want to have a pregnancy test now?

Have You Ever Had The Following:

- ☐ A tooth extraction?
- ☐ Periodontal (gum) surgery?
- ☐ Orthodontic (braces) treatment?
- ☐ Endodontic (root canal) treatment?
- ☐ A crown (capped tooth) or a bridge?
- ☐ Dental implant surgery?
- ☐ A denture (dental plate) or a partial?
- ☐ An injury to your teeth or jaw?
- ☐ Radiation therapy for a tumor?
- ☐ Do you smoke?
- ☐ Use smokeless tobacco?
- ☐ Consume alcoholic beverages?

- ☐ An unusual reaction to any dental treatment? _____
- ☐ An unpleasant experience to any dental treatment? _____
- ☐ Delayed or difficulty healing after an injury or surgery? _____
- ☐ Any disease, condition or health problem Dr. Carey should know about? _____
- ☐ Do you wish to speak with Dr. Carey privately about anything?

I understand the importance of a truthful health history to assist Dr. Carey in providing the best care possible. I certify that I have read and understand the above questions and have answered them to the best of my ability.

X _____ _____

SIGNATURE OF THE PERSON COMPLETING THIS FORM STAFF INITIALS

THANK YOU!