

PATIENT MEDICAL HISTORY

Patient's Name _____ Date ____/____/____

Male Female Married Single Minor (under 18 years)

It is vitally important to the success of any dental treatment that all information on this form be completed in its entirety.

Have you been admitted to a hospital or needed emergency care within the past two years? Yes No

If yes, please explain _____

Have you been treated by a physician within the past two years? (other than a routine visit) Yes No

If yes, please explain _____

Physician's Name _____ Phone Number _____

Please list current medications _____

Are you required to use pre-medication before dental treatment? Yes No

Do you smoke or chew tobacco? Yes No

Your dental appointment *experience* is very important to our entire dental team. Please circle the number below that best describes you when visiting the dental office. Rating: 0 = No Reaction through 10 = Severe

Dental Anxiety 0 1 2 3 4 5 6 7 8 9 10 **Gag Reflex** 0 1 2 3 4 5 6 7 8 9 10

Have you ever been prescribed bisphosphonates? (i.e. Actonel; Fosamax, etc.) Yes No

If yes, please explain _____

Have you ever had complications following dental treatment? Yes No

If yes, please explain _____

Please check if you have allergies to the following listed below:

- | | | | | |
|-------------------------------------|----------------------------------|--------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Codeine | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthetics | |

Please list medications with allergic reactions _____

Please check below if you **have** or **have ever** had the following

- | | | |
|---|---|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Allergies (or Hives) | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anorexia Nervosa | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Joints (date ___/___/___) | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Sjogren's Syndrome |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sleep Apnea (C-Pap) |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Hepatitis (type ____) | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Herpes Virus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Body Dysmorphia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Jaw Joint Pain (TMJ) | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Lung Disease | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Cushing's Disease | <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous/Anxiety Therapy | |

Do you have any disease(s) and/or conditions that are not listed above? Yes No
If yes, please explain _____

Do you have any health problems that need further clarification? Yes No
If yes, please explain _____

Women: Are you pregnant? Yes No
Are you taking birth control pills? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If any changes occur pertaining to my health or if my medications change, I will inform the dental practice of Scruggs & Molina during my next dental visit.

Patient's Signature

Doctor's Signature

Date

