Time 5:03 PM | Marion Family Dental | Date 9/17/2018

Medical and Dental History

Patient Name: | Birth Date: | Date Created:

Dental History

Do you have a specific dental issue?	◯ Yes ◯ No	If yes
Do you have dental examinations on regular basis? When was your last exam?	◯ Yes ◯ No	If yes
Do you have gum disease or active decay?	◯ Yes ◯ No	If yes
Are you happy with your smile? Have your previous dental visits been pleasant?	◯ Yes ◯ No	If yes
Do you have popping, clicking, or discomfort in jaw joint? Do you clench or grind?	◯ Yes ◯ No	If yes

Medical History

Are you under a physician's care now? Why? Who?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head of neck injury?	◯ Yes ◯ No	If yes
Are you taking medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you or have you ever taken Phen-Fen, Redux, Fosamax, Boniva, Actonel, or any other medication	◯ Yes ◯ No	If yes

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Are you taking blood thinners?	◯ Yes ◯ No	If yes
Do you use controlled substances?	☐	If yes
Other?	☐	If yes

Women: Are you,

☐ Pregnant ☐ Nursing/Trying to get pregnant ☐ Taking oral contraceptives

Do you have, or have you had, any of the following? Please check appropriate boxes. *If yes to any of the starred conditions, please let us know in case pre-medication is rec

AIDS/HIV Positive	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hepatitis B	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Drug/Alcohol Addiction	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rhematic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve*	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint*	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heatbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Bacterial Endocarditis*	◯ Yes ◯ No	Faint/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion (Recent)	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	STD's	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Mitral Valve Prolapse*	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Night Sweats	◯ Yes ◯ No	Swilling of Limbs	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Thryoid Disease	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteonecrosis of Jaw Joints	◯ Yes ◯ No	Tonsilitis	◯ Yes ◯ No
Cochlear Implants	◯ Yes ◯ No	Heart Murmer or Defect*	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Pacemaker*	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder*	◯ Yes ◯ No	Heart Trouble/Disease*	◯ Yes ◯ No	Pre Medication?	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Coronary Stent*	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Pulmonary Shunt*	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed?	☐	If yes

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrec information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____