DENTISTRY AT
HICKORY FLAT

MEDICAL HISTORY

PATIENT NAME: _____DOB: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important inter-relationship with the dental treatment you will receive.

Thank you for answering the following questions to help serve you better.

What would you rate your anxiety level for Dental Treatment? ☐ Low ☐Average ☐slightly above Average ☐High

Have you been told you need PRE-MEDICATED before dental treatment and/or cleaning? ☐YES ☐NO

Are you under a physician's care? ☐YES ☐NO If yes please explain_____

Have you ever been hospitalized or had major surgery? ☐YES ☐NO If yes please explain_____

Have you ever had a serious head or neck injury? ☐YES ☐NO If yes please explain_____

Do you, or have ever taken Phen-Fen or Redux? ☐YES ☐NO If yes please explain_____

Are you on a special Diet? ☐YES ☐NO If yes please explain_____

Do you use tobacco products? ☐YES ☐NO If yes how often_____

Do you use controlled substances? ☐YES ☐NO If yes please explain_____

ARE YOU TAKING ANY MEDICATIONS? ☐YES ☐NO If yes please explain_____

Women Only: Are you pregnant or trying to get pregnant? ☐YES ☐NO if yes how far along are you_____

Taking oral contraceptives? ☐YES ☐NO Nursing? ☐YES ☐NO

ALLERGIES: please check all that apply

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

☐Other: _____

Do you or have you ever had any of the following: *Please check all that apply*

☐Anemia	☐High Cholesterol	☐Arthritis	☐Jaundice
☐Artificial Joints	☐Kidney Disease	☐Asthma	☐Liver Disease
☐Low Blood Pressure	☐Blood disease	☐Back Problems	☐Mitral Valve Prolapse
☐Cancer	☐Migraine Headaches	☐Cold Sore/Fever Blister	☐Hypoglycemia
☐Nervous Disorder	☐Diabetes	☐Physical Disability	☐Head / Neck Injuries
☐Depression	☐Psychiatric Problems	☐Drug addiction	☐Stroke
☐Pacemaker	☐Epilepsy/Seizures	☐Radiation /Chemo	☐TM J (jaw joint pain)
☐Excessive Bleeding	☐Respiratory/ Breathing Problems	☐Fainting/Dizzy Spells	☐Tuberculosis
☐Glaucoma	☐Sinus/ Hay Fever	☐HIV Positive	☐Tumor or growth
☐Stomach Problems	☐High Blood Pressure	☐Rheumatic or Scarlet Fever	☐Heart Murmur
☐Heart Attack/Failure	☐Hepatitis (☐A ☐B ☐C)	☐Thyroid Disease	

☐Other:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can Be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes & updates to my medical health status.

Signature: _____ Date:_____

(Patient/Parent or Guardian)