

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

- | | | | |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Radiation/Chemo |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus/Hay Fever |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Head/Neck Injuries | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cold Sore/Fever Blister | <input type="checkbox"/> Hepatitis (<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C) | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> TM J (jaw joint pain) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Tumor or growth |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Problems | |
| <input type="checkbox"/> 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: _____
(Patient or Parent/Guardian)

Date: _____