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| **DENTAL PATIENT MEDICAL HISTORY**  *(This Form is Subject to the Privacy Act of 1974)* | | | | | | | | | | | |
| NAME (*Last, First, Middle Initial*) | | |  | BIRTHDATE | | | | | | | |
| AGE | | | | | | | |
| The Answers To The Following Questions Will Assist The Dentist In Evaluating Your General Health Prior To Providing Your Dental Treatment  **PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE** | | | | | | | | | | | |
| 1. WHAT IS YOUR IMPRESSION OF YOUR PRESENT OVERALL HEALTH? | | | | | | 2. YEAR OF LAST MEDICAL PHYSICAL? | | | | | |
| 3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT: | | | | | | | | | | | |
| Heart Disease or Condition Rheumatic Fever Asthma Hepatitis Venereal Disease  Angina Pectoris Stroke Hay Fever Thyroid Disease (Syphilis, Gonorrhea)  Frequent Chest Pains Hemophilia Emphysema Glaucoma Drug Addiction  High Blood Pressure Bruise Easily Tuberculosis (TB) Epilepsy or Seizure Psychiatric Treatment  Shortness of Breath Prolonged or Unusual Bleeding Diabetes Fainting or Dizzy Spells Cancer  Swollen Ankles Anemia Ulcers AIDS or AIDS related complex Radiation Therapy  Artificial Heart Valve Blood Transfusion Kidney Trouble HIV Positive Chemotherapy  Congenital Heart Disease Sickle Cell Disease Liver Disease Cold Sores Implant Prosthesis  Heart Murmur Arthritis Jaundice (other than birth) Unexplained Weight Loss | | | | | | | | | | | |
| **CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS** (If in Doubt, CIRCLE YES) | | | | | | | | | | | |
| 4. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE PAST YEAR? | | | | | | | | | | Yes | No |
| 5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS (OVER-THE-COUNTER/ PRESCRIPTION/ HERBAL SUPPLEMENTS)? | | | | | | | | | | Yes | No |
| 6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS (INCLUDING LATEX)? | | | | | | | | | | Yes | No |
| 7. HAVE YOU EVER HAD A REACTION TO LOCAL ANESTHETIC? | | | | | | | | | | Yes | No |
| 8. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT? | | | | | | | | | | Yes | No |
| 9. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT MENTIONED ABOVE? | | | | | | | | | | Yes | No |
| 10. HAVE YOU EVER TAKEN BISPHOSPHONATES (FOSAMAX, BONIVA)? | | | | | | | | | | Yes | No |
| 11. HAVE YOU EVER BEEN TOLD TO TAKE ANTIBIOTICS PRIOR TO DENTAL CARE? | | | | | | | | | | Yes | No |
| 12. DO YOU USE TOBACCO? CIRCLE TYPE: SMOKE SMOKELESS FREQUENCY: | | | | | | | | | | Yes | No |
| 13. WOMEN - ARE YOU PREGNANT? IF YES CIRCLE TRIMESTER 1 2 3 | | | | | | | | | | Yes | No |
| **SIGNATURE OF PATIENT (Or Legal Guardian)** | | | | | **DATE** | | | | | | |
| **DENTIST COMMENTS**      **COMMENTS ON BACK: Yes/No** | | | | | | | | | | | |
| BLOOD PRESSURE | DATE | BLOOD PRESSURE | DATE | | | | BLOOD PRESSURE | | DATE | | |
| **DENTIST SIGNATURE** | | **DATE** | **REVIEWER/DATE** | | | | | **REVIEWER/DATE** | | | |

**SILVER CREEK FAMILY DENTAL**