westervilledentalassociates

Medical History

(Please check Yes or No)

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____
Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please list _____

Have you ever taken medication for bone density or osteoporosis? ☐ Yes ☐ No If yes, please list _____
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives: ☐Yes ☐No Nursing: ☐Yes ☐No

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs ☐
Other ☐ If yes, please explain _____

PLEASE CHECK MARK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatism
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Shingles
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Sickle Cell Disease
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure*	☐ Liver Disease	☐ Sinus Trouble
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Low Blood Pressure	☐ Spina Bifida
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Lung Disease	☐ Stomach/Intestinal Disea
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Swelling of Limbs
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Tonsillitis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tuberculosis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tumors/Growths
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Ulcers
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Venereal Disease
			☐ Rheumatic Fever*	☐ Yellow Jaundice

If you checked yes to cancer, please detail: Type_____
When_____ Medications/ treatment _____

DENTAL HISTORY

TO HELP US SERVE YOU BETTER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have specific dental problems or concerns? _____

When was your last dental visit? _____ What was done? _____

Do your gums bleed? _____ Have you been told you have periodontal disease? ____If yes, when? _____What was done? _____

How do feel about your smile? _____Have you ever thought of changing/ improving your smile? _____

Do you snore?_____ Does your snoring disturb others?_____ Do you suffer from sleep apnea?_____ Do you use a CPAP?_____

How do you feel about being here today? _____

I HAVE ACCURATELY COMPLETED THIS FORM AND I WILL NOTIFY THIS OFFICE OF ANY CHANGES IN MY MEDICAL OR DENTAL INFORMATION.

_____ DATE _____
SIGNATURE RESPONSIBLE PARTY