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MEDICAL HISTORY FORM

PATIENT'S NAME: ______________________________ DATE OF BIRTH: ______________________

ADDRESS: ____

CITY: ____ **STATE:** __________ **ZIP CODE:** ___________

BILLING ADDRESS (if different): ____

E-MAIL ADDRESS: ____

CELL: ______________________________ **HOME/ALT PHONE:** _____________________________

EMERGENCY CONTACT: _____________________________ **RELATIONSHIP:** __________________

EMERGENCY CONTACT PHONE: ____

REFERRED BY: ____

PHYSICIAN'S NAME: ____ **PHONE:** _________________

PHYSICIAN'S ADDRESS: ____

DATE OF LAST PHYSICAL: ____

Are you under the care of a recent or ongoing medical condition? ___________________________

If yes, please explain: ____

Have you ever been hospitalized or had a major operation within the last year? ________________

If yes, please explain: ____

Have you had any serious medical issues associated with any dental treatment? _______________

If yes, please explain: ____

Have you been advised to take antibiotics before a dental appointment? _____________________

If yes, please explain: ____

PLEASE CHECK IF YOU HAVE HAD or HAVE ANY OF THE FOLLOWING CONDITIONS:

__ AIDS/HIV POSITIVE
__ ALZHEIMER'S DISEASE
__ ANAPHYLAXIS
__ ANEMIA
__ ARTHRITIS
__ ARTIFICIAL HEART VALVE
__ ARTIFICIAL JOINT
__ ASTHMA
__ BLOOD DISEASE
__ BLOOD TRANSFUSION
__ BREATHING PROBLEMS
__ BRUISE EASILY
__ CANCER
__ CHEMOTHERAPY
__ CHEST PAINS
__ COLD SORES
__ CONGENIAL HEART D.
__ DIABETES
__ DRUG ADDICTION
__ EMPHYSEMA
__ EPILEPSY or SEIZURES
__ EXCESSIVE THIRST

__ FAINTING SPELLS/DIZZINESS
__ FREQUENT COUGH
__ FREQUENT HEADACHES
__ GLAUCOMA
__ HAY FEVER
__ HEART ATTACK/FAILURE
__ HEART MURMUR
__ HEART PACEMAKER
__ HEART TROUBLE//DISEASE
__ HEMOPHILIA
__ HEPATITIS A
__ HEPATITIS B or C
__ HIGH BLOOD PRESSURE
__ HIGH CHOLESTEROL
__ HYPOGLYCEMIA
__ KIDNEY PROBLEMS
__ LEUKEMIA
__ LIVER DISEASE
__ LEUKEMIA
__ LIVER DISEASE
__ LOW BLOOD PRESSURE
__ LUNG DISEASE

__ M.VALVE PROLAPSE
__ OSTEOPOROSIS:SEE BELOW
__ HISTORY OF TAKING BISPHOSPHONATES IV/ORAL
__ PSYCHIATRIC CARE
__ RADIATION TREATMENTS
__ RECENT WEIGHT LOSS
__ RENAL DIALYSIS
__ RHEUMATIC FEVER
__ RHEUMATISM
__ SCARLET FEVER
__ SHINGLES
__ SINUS TROUBLE
__ STOMACH /INTESTINAL D.
__ STROKE
__ THYROID DISEASE
__ TUBERCULOSIS
__ TUMORS or GROWTHS
__ ULCERS
__ OTHER: FILL IN BELOW
____
____

Do you have any disease, condition or medical problem not listed you feel we should know?

Please explain:

____
____
____

CURRENT MEDICATIONS and DOSAGE INCLUDING OVER THE COUNTER AND HERBAL:

____
____
____
____
____
____
____
____
____
____

ALLERGIES: Are you allergic to any drugs, food, environment, animals? Please explain:

____
____
____
____

NOTES SECTION FOR SALEM DENTAL ARTS:

____
____
____
____
____
____

DENTAL HISTORY

What is your chief complaint concerning your mouth or teeth?
____
____

Have you had any serious trouble associated with any previous dental treatment? _____________

If yes, please explain: ____

Have you had any undesirable reaction to local or general anesthetics? ______________________

If yes, please explain: ____

Are you dissatisfied with the appearance of your teeth? ____________________________________

If yes, please explain: ____

Do you clench or grind your teeth? ____

If yes, please explain: ____

Do you have pain in the face, cheeks, jaw, throat or temples? _______________________________

If yes, please explain: ____

Are your teeth sensitive to cold, hot or sweets? ____

If yes, please explain: ____

Do you have bleeding gums? ____

If yes, please explain: ____

Do you gag easily? ____

If yes, please explain: ____

Is there any other information you would like to share with Salem Dental Arts concerning your care? Please explain: ____

____

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 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: ______________________________ ***Date:*** __________

Reviewed by Signature: ____ ***Date:*** _________