Artistic Dentistry Medical/Dental History

Please Complete the Following *Confidential* Medical/Dental History Information

Patient Name: _____ **Date:** _____

Primary Care Physician: _____ Dr. Phone #: _____

Medical Specialist: _____ Dr. Phone #: _____

Preferred Pharmacy/Location: _____

Are you under ongoing Medical Care now? **YES NO** For What Condition? _____

Any Surgery/Hospital visit in the last 3 years? **YES NO** Please explain Procedures/Conditions:

_____

Do you take an **antibiotic pre-medication** prior to dental visits? **YES NO** Name of Medication: _____

Please List ALL **Medications/Supplements** you currently take: _____

_____

_____

Have you ever taken Bone Density Drugs? (Fosamax, Boniva, etc) **YES NO** Drug Name/How Long? _____

Please **circle** any medications/materials you are **Allergic** to? Anesthetics Latex Penicillin Sulfa Aspirin Metals Codeine

List any ALL other **Allergies**: _____

_____

Do you use tobacco and/or controlled substances? If yes, list type and frequency: _____

Please circle YES or NO for *each item* that you have now or have had before:

YES NO Abnormal Bleeding
YES NO AIDS/HIV Positive
YES NO Alzheimers
YES NO Anemia
YES NO Angina
YES NO Arthritis/Gout
YES NO Artificial Joint / Bone
YES NO Asthma
YES NO Blood Disease
YES NO Bruise Easily
YES NO COPD
YES NO Cancer _____
YES NO Chemo / Radiation
YES NO Chest Pains
YES NO Cold Sores
YES NO Colitits
YES NO Diabetes

YES NO Emphysema
YES NO Epilepsy / Seizures
YES NO Fainting / Dizziness
YES NO Glaucoma
YES NO Heart Attack / Failure
YES NO Heart Disease
YES NO Heart Murmur
YES NO Heart Pacemaker
YES NO Heart Surgery
YES NO Heart Valves (Artificial)
YES NO Hemophelia
YES NO Hepatitis Type____
YES NO High Blood Pressure
YES NO High Cholesterol
YES NO Hypoglycemia
YES NO Jaundice
YES NO Kidney Problems

YES NO Liver Disease
YES NO Low Blood Pressure
YES NO Lung Disease
YES NO Mitral Valve Prolapse
YES NO Osteoporosis
YES NO Psychiatric Care
YES NO Rheumatic Fever
YES NO Shingles
YES NO Sickle Cell Disease
YES NO Sinus Problems
YES NO Stomach Disease
YES NO Stroke
YES NO Substance Abuse
YES NO Swelling of Limbs
YES NO Thyroid Problems
YES NO Tuberculosis
YES NO Ulcers

YES NO Neck/Jaw Injury
YES NO Clench / Grind Teeth
YES NO Jaw Click / Pop
YES NO Bleeding Gums
YES NO Frequent Headaches
YES NO Orthodontic Treatment

WOMEN ONLY, Are you currently:
YES NO Pregnant
YES NO Nursing
YES NO Taking Birth Control

Any Condition Not Listed:

_____

Do you wear dentures or partials? **YES NO** Upper - How Long? _____ Lower - How Long? _____

Have you had regular dental care? **YES NO** Date of Last Visit to Dentist? _____

Do you have dental pain / problems today? **YES NO** Please Describe: _____

Please inform us of any special needs during dental treatment: _____

Signature of Patient (If patient is a minor, Signature of Guardian) Date