MM DENTISTRY

Medical History

Patient Name (First, MI., Last):_____ Date of Birth: _____/_____/_____

Physician Name: _____ Phone: _____ Date of last visit: _____
Are you currently under a physician care? ☐ Yes ☐ No If yes, explain: _____
Have you had any serious illnesses, operations, or been hospitalized? ☐ Yes ☐ No If yes, please explain_____
Have you ever taken Phen-Fen/Redux? ☐ Yes ☐ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No
Medications you are currently taking (including over-the-counter): _____
_____
Do you use tobacco? ☐ Yes ☐ No If yes, What kind?_____ How many years? _____ How often?_____
Do you consume alcohol? ☐ Yes ☐ No If yes, How often?_____
Women Only:
Are you currently pregnant/possibly pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following (leave blank if none):

☐ Aspirin	☐ Barbiturates	☐ Iodine	☐ Local Anesthetics	Other: _____
☐ Antibiotics (e.g. Penicillin)	☐ Codeine	☐ Latex	☐ Sulfa Drugs	

Check any of the following which applies to you (leave blank if none):

☐ AIDS/HIV Positive	☐ Drug Addiction	☐ Kidney Disease	☐ Sickle Cell Disease
☐ Alzheimer's Disease	☐ Epilepsy/Seizures	☐ Leukemia	☐ Sinus Troubles
☐ Anemia	☐ Excessive Thirst	☐ Liver Disease	☐ Skin Rash/Hives
☐ Angina	☐ Fainting Spells/Dizziness	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis or Rheumatism	☐ Frequent Coughs	☐ Lung Disease	☐ Stomach Intestinal Disease
☐ Artificial Heart Valve	☐ Genital Herpes	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joints/Replacements	☐ Glaucoma	☐ Osteoporosis	☐ Surgical Implant (s)
☐ Asthma	☐ Hay Fever/Seasonal Allergies	☐ Pacemaker	☐ Swelling of Limbs
☐ Back Problems	☐ Headaches/Migraines	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Bruise Easily/Bleeding	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Tonsilitis
☐ Cancer	☐ Heart Disease	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Murmur/Irregular Beat	☐ Radiation Treatment	☐ Tumors or Growths
☐ Circulatory Problems	☐ Hemophilia	☐ Rapid Gain or Weight Loss	☐ Ulcers/Colitis
☐ Congenital Heart Disorders	☐ Hepatitis - Type : _____	☐ Respiratory Disease	☐ Venereal Disease
☐ COPD/Emphysema	☐ Herpes/Cold Sores	☐ Rheumatic Fever	☐ Other: _____
☐ Cortisone Treatments	☐ High Blood Pressure	☐ Scarlet Fever	☐ Comments: _____
☐ Diabetes Type (1 or 2) : _____	☐ High Cholesterol	☐ Shingles	_____

Dental History

Previous Dental Office/Location: _____ Date of Last Dental Exam/Cleaning: _____
Date of Last Dental X-Rays: _____ Are you in dental discomfort ?_____
Are you happy with the appearance of your teeth/smile? ☐ Yes ☐ No If no, explain_____
How often do you brush? _____ How often do you floss? _____
Have you ever had any adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No
If yes, please explain: _____

Check if you have had any of the following (leave blank if none):

☐ Bleeding Gums	☐ Grinding/Clenching teeth	☐ Prolonged bleeding after extractions
☐ Difficulty opening or closing of jaw	☐ Headaches	☐ Sensitivity to hot/cold/sweets
☐ Difficult extractions in the past	☐ Jaw pain/TMJ	☐ Sensitivity when biting/chewing
☐ Dry Mouth	☐ Loose/broken teeth or fillings	☐ Sores or growths in mouth
☐ Dental Anxiety/Fear	☐ Orthodontic Treatment	☐ Swollen tender gums
☐ Denture/Partials	☐ Periodontal (gum) Treatment	☐ Other: _____

To the best of knowledge, the questions on this form has 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.

Patient's Name (printed):_____ Date: _____/_____/_____

Patient/Parent/Guardian (print & signature): _____

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