The Main Street Dentists

Patient Medical and Dental History

PATIENT NAME:_____ **Date**:_____

MEDICAL HISTORY

1.What is your impression of your present health? _____ Date of last physical examination?_____

Please Circle:

Yes No **2.** Has there been any change in your general health within the last year?
Yes No **3.** Are you presently, or have you been, under the care of a physician during the past year?
Yes No **4.** Have you had any serious illness, operation, or been hospitalized within the last 5 years?
Yes No **5.** Are you taking any medicine(s), including non-prescription drugs?
Yes No **6.** Have you taken, or are you now taking, steroids?
Yes No **7.** Do you have, or have you had, a problem with alcohol or drug abuse?
Yes No **8.** Do you use, or have you used, tobacco products? (Smoke/Smokeless)
Yes No **9.** ***WOMEN:*** Are you pregnant?
Yes No **10.** ***WOMEN:*** Do you take birth control pills?

11. Are you allergic or have you had a reaction (swelling, rash, itching) to any of the following?

Please Circle All That Apply:

Penicillin or other antibiotics	Other drugs or medications	Metals/Jewelry
Local anesthetics (numbing agents)	Latex/Rubber products	Other:

12. Have you now, or in the past, had any of the following?

Please Circle All That Apply:

Heart trouble/surgery	Emphysema	AIDS or HIV infection
Chest pain	Tuberculosis	Herpes
Rheumatic Fever	Persistent cough	Syphilis/Gonorrhea
Heart murmur	Anemia/blood diseases/prolonged bleeding	Scalp or Skin disease
Irregular heart beat	Leukemia/Bone disorders	Epilepsy(convulsions,seizures,fainting,dizziness)
Mitral valve prolapse	Jaundice or other liver problems	Arthritis or painful swollen joints
Pacemaker	Diabetes/Family history of diabetes	Artificial joints
High blood pressure	Thyroid problems	Stomach or intestinal problems
Stroke	Kidney or bladder problems/Dialysis	Emotional problems/nervous disorders
Shortness of breath	Cancer or tumor	Indwelling catheter/shunt
Hay fever/Asthma	Lumps or swollen glands in neck or armpit	Pneumonia
Sinus Problems	Hepatitis	Gastrointestinal disorders
Other:	Other:	Other:

Medications You Take:

1.	**5.**	**9.**
2.	**6.**	**10.**
3.	**7.**	**11.**
4.	**8.**	**12.**

DENTAL HISTORY

Primary reason for this appointment: ____Examination ____Emergency ____Consultation

Please Circle:

Yes No **1.** Do you have a dental problem?
Describe:_____
Yes No **2.** Do you receive routine dental care?
Last visit:_____
Treatment received:_____
Last cleaning:_____
Last x-rays:_____
Yes No **3.** Do you have sensitive or sore teeth?
To what?_____
Yes No **4.** Are you unhappy with the appearance of your teeth?
Yes No **5.** Have you had problems or complications with past dental care?
Yes No **6.** Does your mouth feel dry?
Yes No **7.** Do you have any other questions or concerns about dentistry or your dental health?

I certify that to the best of my knowledge the above information is complete and accurate. If there are changes in my health, or medicines, I will inform my doctor at the next appointment.

Patient/Guardian Signature:_____Date:_____