PATIENT MEDICAL/DENTAL HEALTH HISTORY

Patient's Name: _____ Date of Birth: _____

CURRENT MEDICAL CONDITIONS:	**CURRENT MEDICATIONS:** (include over the counter & herbal)	**ALLERGIES:**

Name of Medical Doctor: _____ Date of last Medical Treatment: _____

Do you have/or have had any of the following? Yes No If yes, Please indicate which of the following:

___ Liver Disease (Hepatitis/ Jaundice) ___ Diabetes

___ Lung Disease ___ Brain Injury or Epilepsy

___ Cancer/ Radiation treatment ___ Bleeding Disorder

___ Joint Replacement ___ Infectious Disease (HIV/ Tuberculosis)

___ Heart Disease (Pacemaker/ Heart murmur/ Valve disease)

Do you smoke or chew tobacco? Yes No

WOMEN ONLY:

Are you pregnant or think you may be? Yes No

Are you nursing? Yes No

Are you using birth control pills or patch? Yes No

DENTAL HISTORY:

Do you have pain or concerns regarding your teeth, mouth, gums, or jaw? Yes No

If you have pain, where is the pain?

_____

On a scale of 1 – 10 how severe is the pain? **MILD 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10 SEVERE**

Have you had any problems with Dental treatment? Yes No

If yes, please explain: _____-

_____

I certify that I have read and understood the above information. To the best of my knowledge the above questions have been accurately answered, I understand that providing incorrect information can be dangerous to my health.

Patient Signature: _____ **Date:** _____

(Or Parent/Legal Guardian if patient is under 18 years old)

Dentist Signature: _____**Date:** _____