Smile Connections Family Dental, L.L.C.

MEDICAL HISTORY

Patient Name ________________________ Preferred Name ______________ D.O.B. ____________

Name of Physician/ and their specialty ____

Most recent physical examination __________________ Purpose ____________________________

What is your estimate of your general health? □ Excellent □ Good □ Fair □ Poor

Recently ill? □ fever □ new cough □ diarrhea

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ___	□	□
2.	an allergic reaction to and type of reaction (i.e. hives, rash, swelling, anaphylaxis)	□	□
	□ aspirin, ibuprofen, acetaminophen, codeine		
	□ penicillin		
	□ erythromycin		
	□ tetracycline		
	□ sulfa		
	□ local anesthetic		
	□ fluoride		
	□ metals (nickel, gold, silver, ______________)		
	□ latex		
	□ acrylic		
	□ other ____________________________		
3.	heart problems, or cardiac stent within the last 6months ________________	□	□
4.	history of infective endocarditis____________	□	□
5.	artificial heart valve, repair heart defect (PFO) ____	□	□
6.	angina, chest pains, carry nitroglycerine tabs _____	□	□
7.	congenital heart disorder, mitral valve prolapse ___	□	□
8.	orthopedic implant (joint replacement) _________	□	□
9.	high or low blood pressure _______________	□	□
10.	a stroke (taking blood thinners) _____________	□	□
11.	anemia, hemophilia, sickle cell or other blood disorders ________________	□	□
12.	prolonged bleeding due to slight cut (INR> 3.5) ___	□	□
13.	lung disease__________________________	□	□
14.	emphysema, shortness of breath, sarcoidosis, COPD ____________________	□	□
15.	asthma, carry a rescue inhaler _____________	□	□
16.	breathing or sleep problem (i.e. sleep apnea, snoring, sinus)____________	□	□
17.	kidney disease, renal dialysis ______________	□	□
18.	liver disease/Jaundice __________________	□	□
19.	thyroid, parathyroid disease, calcium deficiency	□	□
20.	high cholesterol or taking statin drugs _________	□	□
21.	Excessive thirst or frequent urination _________	□	□
22.	diabetes (HbA1c=___) ____________________	□	□
23.	hypoglycemia _________________________	□	□
24.	stomach or duodenal ulcer _______________	□	□
25.	digestive disorders (i.e. celiac disease)_________	□	□
26.	acid reflux/ GERD/frequent cough/throat clearing	□	□
27.	osteoporosis/ osteopenia (i.e. taking bisphosphonates) _____________	□	□
28.	arthritis ______________________________	□	□
29.	autoimmune disease ___________________ (i.e. rheumatoid arthritis, lupus, scleroderma)	□	□
30.	cortisone medicine history ____________	□	□
31.	glaucoma ____________________________	□	□
32.	head, neck, or jaw injuries _______________	□	□
33.	epilepsy, convulsions (seizures) ____________	□	□
34.	fainting spells/ dizziness ________________	□	□
35.	neurologic disorders (i.e. ADD/ADHD, prion disease) ____________	□	□
36.	viral infections and cold sores/ fever blisters _____	□	□
37.	any lumps or swelling in the mouth __________	□	□
38.	blood transfusions _____________________	□	□
39.	hepatitis (type _____) __________________	□	□
40.	HIV/AIDS/HPV/Herpes/STD_______________	□	□
41.	cancer, tumor, abnormal growth, leukemia ______	□	□
42.	radiation therapy to the head or neck _________	□	□
43.	chemotherapy, immunosuppressive medication __	□	□
44.	Alzheimer’s disease, dementia _____________	□	□
45.	bulimia/ anorexia _____________________	□	□
46.	psychiatric treatment ___________________	□	□
47.	antidepressant medication _____________	□	□
48.	alcohol/ recreational drug use /drug addiction____	□	□
	ARE YOU:		
49.	experiencing unexplained weight loss ________	□	□
50.	taking dietary supplements ____________	□	□
51.	often exhausted/ fatigued/ easily winded _______	□	□
52.	experiencing frequent headaches or migraines ___	□	□
53.	a smoker, smoked previously or use smokeless tobacco ________________	□	□
54.	often unhappy or depressed _______________	□	□
55.	taking birth control pills _________________	□	□
56.	currently pregnant/ trying to become pregnant ___	□	□
57.	currently nursing ______________________	□	□
58.	experiencing dry mouth _________________	□	□
59.	presently being treated for any other illness _____	□	□

Describe any current medical treatment, impending surgery, genetic/ development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years on the attached form.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member or his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If I ever have any changes in my health, or if my medications change, I will inform my Dentist and his/her staff.

Patient Signature: ________________________________ **Date:** ____________________

Doctor’s Signature: ________________________________ **Date:** ____________________

Smile Connections Family Dental

Name____________________________ D.O.B.____________________Date____________________________

Prescribed Medication Name	Dosage	Purpose

Over-the-counter Medication Name	Dosage	Purpose