DENTAL AND MEDICAL HISTORY **PATIENT NAME:** ______________________________

Date of Last Dental Visit: ____________ Name of Previous Dentist:______________________________

Date of Last Medical Examination: __________ Physician: ________________________ Phone:____________

Reason for this visit: ____

Have you ever had or been treated for any of the following? Please check those that apply:

- ☐ Artificial Joints ***(PR/MCR)***
- ☐ Blood Disease ***(PR)***
- ☐ Heart Attack ***(PR)***
- ☐ Heart Disease ***(PR)***
- ☐ Heart Murmur ***(PR/MCR)***
- ☐ Kidney Disease ***(PR/MCR)***
- ☐ Liver Disease ***(PR/MCR)***
- ☐ Pacemaker ***(PR)***
- ☐ Allergies ____________________________
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bruise easily/Blood disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug/Alcohol Dependency
- ☐ Epilepsy ***(MCR)***
- ☐ Excessive Bleeding ***(MCR)***
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Hepatitis ***(MRC)***
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Mononucleosis
- ☐ Jaundice or Hepatitis
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ **Pregnancy *(MCR)***
  Due date:__________
- ☐ Radiation Treatment ***(MCR)***
- ☐ Respiratory Problems
- ☐ Rheumatic Fever ***(PR)***
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke ***(PR/MCR)***
- ☐ Tuberculosis ***(MRC)***
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ ________________
- ☐ ________________

MAY BE REQUIRED:
PREMEDICATION (PR):
MED CLEARANCE (MCR)

1. Are you worried about receiving dental treatment or excessively nervous? ☐ Yes ☐ No____________________
2. Do you have difficulty chewing your food or opening your mouth wide? ☐ Yes ☐ No____________________
3. Do you have sensitive teeth, bleeding gums, or sore gums? ☐ Yes ☐ No____________________
4. Do you have canker sores, cold sores, or a sore mouth? ☐ Yes ☐ No____________________
5. Do you ever have sores in the mouth or on the lips that are slow to heal? ☐ Yes ☐ No____________________
6. Have you ever had any injury to your face or jaws? ☐ Yes ☐ No____________________
7. Are you being treated by a physician for any condition at the present time? ☐ Yes ☐ No____________________
   If yes, please explain:____
   Name of Physician: ________________________________ Phone:____________________
8. Are you taking any ☐ prescription or ☐ non-prescription medicines
   (ANY form of pills, tablets, or syrups) in the past six months ☐ Yes ☐ No____________________
9. Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
   If yes, please explain:____
10. Have you ever had a blood transfusion or general anesthetic? ☐ Yes ☐ No____________________
11. Have you ever been treated for a tumor or cancer by x-ray, chemotherapy, or surgery? ☐ Yes ☐ No________________
12. Have you ever experienced an unusual reaction to any of the following drugs?

Aspirin	☐	Yes	☐	No	Penicillin	☐	Yes	☐	No
Barbiturates	☐	Yes	☐	No	Sulfonamides	☐	Yes	☐	No
Dental Anesthetic	☐	Yes	☐	No	Other (specify):				

13. Are you frequently ill or often exhausted or fatigued? ☐ Yes ☐ No____________________
14. Do you have asthma, hay fever, hives, skin rash, or allergies? ☐ Yes ☐ No____________________
15. Do you bleed for a long time when cut? ☐ Yes ☐ No____________________
16. Do you have headaches, eye trouble, or ear trouble? ☐ Yes ☐ No____________________
17. Do you ever have chest pain, shortness of breath, or swelling of the ankles? ☐ Yes ☐ No____________________
18. Do you have a chronic cough or do you ever cough up blood? ☐ Yes ☐ No____________________
19. Do you urinate frequently or drink large amounts of liquids? ☐ Yes ☐ No____________________
20. Have you ever had painful swollen joints or numb or prickling skin? ☐ Yes ☐ No____________________
21. Do you ever have fits or convulsions, or a tendency to faint? ☐ Yes ☐ No____________________
22. Have you ever had any complications following dental treatment? ☐ Yes ☐ No____________________
    If yes, please explain:____
23. Do you have any health problems that need further clarification? ☐ Yes ☐ No If yes, please explain below:
    ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian	Date	Doctor's signature	Date