Davis Family DENTISTRY

Medical History

PATIENT NAME: _____ DOB: ____/____/_____

ARE YOU UNDER A PHYSICIAN'S CARE NOW? YES NO

IF YES, PLEASE EXPLAIN_____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? YES NO

IF YES, PLEASE EXPLAIN_____

HAVE YOU EVER HAD SERIOUS HEAD OR NECK INJURY? YES NO

IF YES, PLEASE EXPLAIN_____

ARE YOU TAKING ANY MEDICATIONS, PILLS OR DRUGS? YES NO

IF YES, PLEASE LIST_____

HAVE YOU BEEN TOLD YOU NEED A PRE-MEDICATION? YES NO

DO YOU USE CONTROLLED SUBSTANCES? YES NO

ARE YOU A WOMAN WHO IS…? ☐ PREGNANT ☐ NURSING ☐ TAKING ORAL CONTRACEPTIVES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ METAL ☐ LATEX ☐ OTHER_____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Pacemaker
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Parathyroid Disease
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

COMMENTS:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered, I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent or Guardian Date