MEDICAL HISTORY

NAME OF PHYSICIAN_____
PHYSICIAN'S PHONE#_____
CURRENT PHYSICAL HEALTH_____GOOD_____FAIR_____POOR
ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN ?_____
ARE YOU TAKING ANY PRESCRIPTION MEDICATIONS ?_____
PLEASE LIST EACH ONE_____
_____

NAME AND ADDRESS OF PHARMACY_____
_____
PHARMACY PHONE #_____

PLEASE MARK ALL OF THE FOLLOWING MEDICAL CONDITIONS THAT APPLY.

___ABNORMAL BLEEDING
___BLOOD TRANSFUSION
___DIABETES
___GLAUCOMA
___EMPHYSEMA
___HEART ATTACK / STROKE
___HEMOPHILIA
___HIV / AIDS
___MITRA VALVE PROLAPSE
___SEVERE / FREQUENT HEADACHES
___ULCERS / COLITIS
___KIDNEY PROBLEMS
___CONGENITAL HEART DEFECT
___DRUG / ALCOHOL ABUSE
___FEVER BLISTERS / HERPES
___ SNORING/SLEEP APNEA
___SINUS PROBLEMS
___CANCER / CHEMOTHERAPY
___ANEMIA / RADIATION TREATMENT
___DIFFICULTY BREATHING
___EPILEPSY / SEIZURES / FAINTING
___HEART MURMUR
___HEPATITIS
___SHINGLES
___PSYCHIATRIC PROBLEMS
___VENEREAL DISEASE
___HOSPITALIZED FOR ANY REASON
___ARTIFICIAL BONES / JOINTS / VALVES
___HEART SURGERY / PACEMAKER
___HIGH / LOW BLOOD PRESSURE
___RHEUMATIC / SCARLET FEVER
___OTHER

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS ?

___PENICILLIN
___LATEX
___CODEINE
___ASPIRIN
___DENTAL ANESTHETICS
___ERYTHROMYCIN
___TETRACYCLINE
___OTHER
PLEASE LIST DRUGS YOU ARE ALLERGIC TO :_____

FOR WOMEN:
ARE YOU PREGNANT _____ ARE YOU NURSING? ____
ARE YOU TAKING BIRTH CONTROL PILLS?_____ ARE YOU TAKING HRT? _____

DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY ?_____

_____

_____

ARE YOU CURRENTLY IN PAIN ? _____YES_____ NO

HAVE YOU EVER HAD SERIOUS / DIFFICULT PROBLEMS ASSOCIATED WITH ANY PREVIOUS DENTAL WORK ? _____YES _____NO

DO YOU HAVE PAIN IN OR NEAR YOUR EARS ? _____YES _____NO

ARE YOU AWARE OF GRINDING OR CLENCHING ? _____YES _____NO

ARE YOUR TEETH SENSITIVE TO HOT OR COLD ? _____YES _____NO

DO YOU OR HAVE YOU EVER EXPERIENCED PAIN OR DISCOMFORT IN YOUR JAW JOINT (TMJ) ? _____YES _____NO

DO YOUR GUMS BLEED OR FEEL TENDER ? _____YES _____NO

HAVE YOU EVER HAD NOVOCAINE ANESTHETICS ? _____YES _____NO

HAVE YOU EVER HAD ANY REACTION TO NOVOCAINE ? _____YES _____NO

HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST ? _____YES _____NO

WHEN WAS YOUR LAST FULL MOUTH X-RAY TAKEN ?

WHERE WAS YOUR FULL MOUTH X-RAY TAKEN ?

I UNDERSTAND THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PREFORM ANY NECESSSARY DENTAL SERVICES WITH MY INFORMED CONSENT THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT.

_____

SIGNATURE DATE

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY. IT WILL ENABLE US TO HELP YOU MORE EFFECTIVELY. IF YOU HAVE ANY QUESTIONS AT THIS TIME, PLEASE ASK US. WE ARE HAPPY TO HELP.

DR. MARGARET A. BEAMER AND STAFF