Dental and Medical History Form

General Information:

Patient's Name _____ Patient Birth Date _____

Do you wear contact lenses? No Yes Are you currently taking diet pills? No Yes

Do you use tobacco products? No Yes If yes, how frequent? _____

For Women: Are you currently taking birth control pills? No Yes

Are you or do you think you may be pregnant? No Yes Due Date _____ Are you nursing? No Yes

Medical History:

Please rate your current physical health (1-10, 10 being best)? _____ Date of Last Physical Exam _____

Have you been hospitalized or undergone surgery of any kind? Please describe _____

_____

Have you ever suffered a major head or neck injury? No Yes If yes, please describe _____

Are you currently taking any drugs or medication? No Yes If yes, please list: _____

_____

Please indicate any allergies: Aspirin Penicillin / Amoxicillin Latex Tetracycline

Other allergies (please explain) _____

Dental History: Date of Last Dental Exam _____

What treatments were performed at your latest dental appointment? _____

Previous Dentist _____ May we request previous dental records? Yes No

Are you currently experiencing pain or discomfort in or near your: Ears Jaw Mouth Neck

If so, please describe _____

Office Use Only (for future appointments):

Any changes in the patient health since the last office visit? No Yes If yes, please describe _____

Any new medications No Yes If yes, please list _____

Health Conditions: *(please indicate if you have had any of the following conditions by checking "Yes" or "No")*

AIDS/HIV Positive	Yes	No	Emphysema	Yes	No	Nervous Problems	Yes	No
Alzheimer's disease	Yes	No	Epilepsy or Seizures	Yes	No	Pain in Joints	Yes	No
Anaphylaxis	Yes	No	Fainting Spells/Dizziness	Yes	No	Parathyroid Disease	Yes	No
Anemia	Yes	No	Frequent Cough	Yes	No	Psychiatric Care	Yes	No
Angina	Yes	No	Frequent Diarrhea	Yes	No	Radiation Treatments	Yes	No
Arthritis/Gout	Yes	No	Frequent Headaches	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valve	Yes	No	Genital Herpes	Yes	No	Scarlet Fever	Yes	No
Artificial Joint	Yes	No	Glaucoma	Yes	No	Shingles	Yes	No
Asthma	Yes	No	Heart Attack/Stoke	Yes	No	Sickle Cell Disease	Yes	No
Blood Disease	Yes	No	Heart Murmur	Yes	No	Sinus Problems	Yes	No
Blood Transfusion	Yes	No	Heart Surgery/Pace Maker	Yes	No	Skin Rash / Hives	Yes	No
Breathing Difficulty	Yes	No	Hemophilia/Excess Bleeding	Yes	No	Spina Bifida	Yes	No
Bruise Easily	Yes	No	Hepatitis (Type _____)	Yes	No	Stomach/Intestinal Disease	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Swelling of Limbs or Feet	Yes	No
Chemotherapy	Yes	No	High / Low Blood Pressure	Yes	No	Swelling of Neck Glands	Yes	No
Chest Pains	Yes	No	Jaundice	Yes	No	Thyroid Disease	Yes	No
Cold Sores/Fever Blisters	Yes	No	Jaw Problems /TMJ /TMD	Yes	No	Tonsillitis	Yes	No
Congenital Heart Disorder	Yes	No	Kidney Problems	Yes	No	Tuberculosis (TB)	Yes	No
Convulsions	Yes	No	Liver Disease	Yes	No	Tumor / Growth	Yes	No
Cortisone Medicine	Yes	No	Lung Disease	Yes	No	Ulcers	Yes	No
Diabetes / Hypoglycemia	Yes	No	Mitral Valve Prolapse	Yes	No	Venereal Disease	Yes	No
Drug / Alcohol Addiction	Yes	No	Neck or Back Problems	Yes	No	Weight Loss (unexplained)	Yes	No

---

I understand the above information and attest that this information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

© Rouse Norton CPA, PA 2014