SWISHER & ASSOCIATES
TOTAL DENTAL CARE

Medical History

Last Name: _____ First Name: _____ Birthdate: _____

Emergency Contact _____ Phone _____ Relationship _____

Do you take any medications? Yes ☐ No ☐ List all medications that you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other Allergies:

_____

_____

_____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Cold Sores/Fever Blisters	☐	☐	Rheumatic Fever
☐	☐	Artificial Heart Valve	☐	☐	Heart Pacemaker
☐	☐	Glaucoma	☐	☐	Joint Replacement (Ex. Hip, Knee, etc.)
☐	☐	HIV / AIDS	☐	☐	Thyroid Problems
☐	☐	Neurological Disorders - If yes, which type?	☐	☐	Hepatitis - If yes, which type?

_____ _____

Do you have any conditions or problems not listed above? If yes, please list.

_____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? Yes ☐ No ☐ Reason for today's visit _____

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____ Are you in pain? Yes ☐ No ☐

Primary Care Physician: _____ Phone Number: _____

Patient or Guardian's Signature: _____

Date: