gagedental FAMILY & COSMETIC

DENTAL & MEDICAL HISTORY

PATIENT NAME: ____ **BIRTH DATE:** ______________________

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication(s) that you may be taking, could have an important correlation with the dentistry you will receive. Thank you for answering the following questions.

Have you ever been hospitalized or had a major operation? Yes No
Have you ever had a serious head or neck injury? Yes No
Are you taking any medication, pills, or drugs? Yes No
Do you use tobacco products? Yes No How often? __________________
Do you have any of the following? (Please Circle) Dentures/Partials Braces Periodontal (gum) problems

Are you allergic or have you reacted adversely to any of the following medications?

☐ Aspirin	☐ Nitrous Oxide	☐ Percodan	☐ Valium	☐ Darvon	☐ Latex	☐ Codeine
☐ Local Anesthetic	☐ Sulfa Drugs	☐ Tetracycline	☐ Penicillin	☐ Iodine	☐ Other:________________	

MEDICAL HSITORY: Please check any of the following problems/conditions that apply to you:

☐ AIDS/HIV	☐ Congenital Heart Disorder	☐ Heart Surgery	☐ Lung Disease	☐ Tonsillitis
☐ Alzheimer Disease	☐ Convulsions	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Anemia	☐ Cortisone Medicine	☐ Hepatitis A	☐ Osteoporosis	☐ Tumors or Growths
☐ Angina(chest pain)	☐ Diabetes	☐ Hepatitis B	☐ Pacemaker	☐ Ulcers
☐ Arthritis/Gout	☐ Drug Addiction	☐ Hepatitis C	☐ Psychiatric Care	☐ Venereal Disease
☐ Artificial Heart Valve	☐ Emphysema	☐ Herpes	☐ Radiation (head/neck)	☐ OTHERS: (Please list below)
☐ Artificial Joint	☐ Epilepsy/Seizures	☐ High Blood Pressure	☐ Respiratory Problems	
☐ Asthma	☐ Excessive Bleeding	☐ High Cholestrol	☐ Rheumatic Fever	
☐ Blood Disease	☐ Fainting/Dizziness	☐ Hives/Rash	☐ Rheumatism	
☐ Blood Transfusion	☐ Frequent Cough	☐ Jaundice	☐ Scarlet Fever	
☐ Breathing problem	☐ Frequent Headaches	☐ Jaw Joint Pain	☐ Seizures	
☐ Bruise Easily	☐ Glaucoma	☐ Kidney Disease	☐ Sinus Problems	
☐ Cancer	☐ Heart Attack/Failure	☐ Leukemia	☐ Stomach Problems	
☐ Chemotherapy	☐ Heart Murmur	☐ Liver Disease	☐ Stroke	
☐ Cold Sore	☐ Heart Conditions	☐ Low Blood Pressure	☐ Thyroid Disease	

WOMEN ONLY: Are you **pregnant**? _Y / N_ If yes, when is your **due date**? _______________ **Nursing?** _________

Current Medications: ____
____
Are you under physician's care now? _Y / N_ if yes, please explain: ______________________________________
Physician's name: ____ Phone Number: _________________________
Preferred Pharmacy: _________________________________Previous Dentist: _____________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that withholding important information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: __________________________________ **DATE:** _____________