Culver Dentistry
THE WOODLANDS

MEDICAL HISTORY

Patient Name ________________________________ **Date of Birth**_________________ **Date**____________

Are you under a Physician's care now Yes No If Yes ____
Have you ever been hospitalized or
Had a major surgery Yes No If Yes____
Are you taking Medications Yes No If Yes ____
____

Have you ever taken Fosamax, Boniva,
Actonel or any other medicine
Containing Bisphosphonates? (women) Yes No If Yes ____
Do you use tobacco Yes No

Women: Are you
Pregnant: Yes No Nursing: Yes No Taking Oral Contraceptives: Yes No

Are you **ALLERGIC** to any of the following

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics
Other ______________________			

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Emphysema	Yes No	Low Blood Pressure	Yes No
Alzheimer's disease	Yes No	Epilepsy or Seizures	Yes No	Mitral Valve Prolapse	Yes No
Anaphylaxis	Yes No	Excessive Bleeding	Yes No	Osteoporosis	Yes No
Anemia	Yes No	Excessive Thirst	Yes No	Pain in Jaw Joints	Yes No
Angina	Yes No	Fainting Spells/Dizziness	Yes No	Parathyroid Disease	Yes No
Arthritis/Gout	Yes No	Frequent Cough	Yes No	Psychiatric Care	Yes No
Artificial Heart Valve	Yes No	Frequent Diarrhea	Yes No	Radiation Treatment	Yes No
Artificial Joint	Yes No	Frequent Headaches	Yes No	Renal Dialysis	Yes No
Blood Disease	Yes No	Heart attack/Failure	Yes No	Rheumatic Fever	Yes No
Blood Transfusion	Yes No	Heart Murmur	Yes No	Scarlet Fever	Yes No
Breathing Problems	Yes No	Heart Pacemaker	Yes No	Shingles	Yes No
Bruise Easily	Yes No	Heart Trouble/Disease	Yes No	Sickle Cell Disease	Yes No
Cancer	Yes No	Hemophilia	Yes No	Sinus Trouble	Yes No
Chemotherapy	Yes No	Hepatitis A	Yes No	Stomach Disease	Yes No
Chest Pains	Yes No	Hepatitis B or C	Yes No	Stroke	Yes No
Cold Sore/Fever Blisters	Yes No	High Blood Pressure	Yes No	Thyroid Disease	Yes No
Congenital Heart Disorder	Yes No	High Cholesterol	Yes No	Tuberculosis	Yes No
Convulsions	Yes No	Hypoglycemia	Yes No	Tumors or Growths	Yes No
Cortisone Medicine	Yes No	Kidney Problems	Yes No	Ulcers	Yes No
Diabetes	Yes No	Leukemia	Yes No	Yellow Jaundice	Yes No
Drug Addiction	Yes No	Liver Disease	Yes No		

Have you ever had any serious illness not listed Yes No If Yes ____

Comments:

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect 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.

X____ Date _____________________________

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DENTAL HISTORY

Reason for today's visit_________________________________ Date of last visit______________

Former dentist: ____

Bad Breath Y/N

Blisters on lips and mouth Y/N

Burning sensation on tongue Y/N

Chew on side of mouth Y/N

Cigarette, pipe or cigar smoking Y/N

Dry Mouth Y/N

Food collection between the teeth Y/N

Periodontal treatment Y/N

Clench or Grind teeth Y/N

Growths or sore spots in your mouth Y/N

Gums swollen, tender or bleeding Y/N

Jaw Pain or tiredness Y/N

Loose Teeth or broken fillings Y/N

Mouth Breathing Y/N

Orthodontic treatment Y/N

Sensitivity to pressure, cold, heat, sweets Y/N

How often do you floss? ______________________ How often do you brush? ______________________

Have you ever had an allergic reaction or allergic symptoms to Novocain, or local or general anesthesia Y/N

Have you had trouble from previous dental care? Y/N: if yes then explain__________________________

AUTHORIZATION AND RELEASE

I have read and answered the above the questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information that is necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid by my insurance or not. I authorize the use of this signature on all insurance submissions.

____ ______________________

Signature of patient or parent if minor Date