Medical History

MAPLEWOOD DENTAL ARTS
providing a lifetime of healthy smiles

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PATIENT INFORMATION

Title _____ Patient's name _____ Nickname _____
Gender: Male Female Date of Birth _____
Emergency Contact _____ Relation to patient _____ Phone _____
Name of physician _____ Most recent physical examination _____

DO YOU HAVE, HAVE YOU HAD, OR ARE YOU…

(please circle YES or NO)

Allergic reactions to any of the following:

Aspirin, ibuprofen, acetaminophen ..... Yes No
Penicillin ..... Yes No
Erythromycin ..... Yes No
Tetracycline ..... Yes No
Codeine ..... Yes No
Local anesthetic ..... Yes No
Fluoride ..... Yes No
Metals (gold, stainless steel) ..... Yes No
Latex ..... Yes No
Other ..... Yes No
Heart problems/heart murmur ..... Yes No
abnormal high/low(circle one)blood pressure....Yes No
Artificial prosthesis (heart valve, joints)..... Yes No
Anemia or other blood disorder ..... Yes No
Rheumatic fever ..... Yes No
Scarlet fever ..... Yes No
A stroke ..... Yes No
Prolonged bleeding due to slight cut ..... Yes No
Tuberculosis ..... Yes No
Asthma/emphysema (circle one) ..... Yes No
Sinus problems ..... Yes No
Kidney disease ..... Yes No
Liver disease..... Yes No
Jaundice ..... Yes No
Thyroid or parathyroid disease ..... Yes No
Hormone deficiency ..... Yes No
High cholesterol ..... Yes No
Diabetes ..... Yes No
Stomach or duodenal ulcer .....Yes No

Digestive disorders..... Yes No
Arthritis ..... Yes No
Glaucoma ..... Yes No
Contact lenses ..... Yes No
Head or neck injuries ..... Yes No
Epilepsy, convulsions (seizures) ..... Yes No
Herpes or shingles ..... Yes No
Lumps or swelling in the mouth ..... Yes No
STD ..... Yes No
Hepatitis (type ___) ..... Yes No
HIV/AIDS ..... Yes No
Autoimmune disorders ..... Yes No
Cancer, tumor, abnormal growth ..... Yes No
Radiation therapy ..... Yes No
Chemotherapy ..... Yes No
Psychiatric treatment ..... Yes No
Antidepressant medication ..... Yes No
Alcohol/drug dependency ..... Yes No
Hospitalization for illness or injury ..... Yes No
If yes, explain on back of this sheet
Have you been told by a physician that you require premed for dental treatment.....Yes No
Presently being treated for illness .....Yes No
A change in general health ..... Yes No
Often exhausted or fatigued ..... Yes No
Subject to frequent headaches ..... Yes No
A smoker ..... Yes No
(female) taking birth control pills ..... Yes No
(female) pregnant ..... Yes No

ADDITIONAL INFORMATION

Describe current medical treatments, impending surgery, or information that may possibly affect your dental treatment

_____

List any medications, herbal supplements, and/or vitamins you are currently taking

_____

The information I've indicated above is accurate to the best of my knowledge.

Signature required _____ Date _____
Doctor's signature _____ Date _____