Palo Alto Dental Group

MEDICAL HISTORY

PATIENT NAME _____

Although dental personnel primarily 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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No Why? _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No Explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No List: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No Do you use tobacco? ○ Yes ○ No

Are you on a special diet? ○ Yes ○ No Do you use controlled substances? ○ Yes ○ No

Woman: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

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

☐ AIDS/HIV Positive	☐ Congenital Heart Disorder	☐ Heart Pace Maker*	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Alzheimer's Disease	☐ Convulsions	☐ Hemophilia	☐ Parathyroid Disease	☐ Tonsillitis
☐ Anaphylaxis	☐ Cortisone Medicine	☐ Hepatitis A	☐ Psychiatric Care	☐ Tuberculosis
☐ Anemia	☐ Diabetes	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tumors or Growths
☐ Angina	☐ Drug Addiction	☐ Herpes	☐ Renal Dialysis	☐ Ulcers
☐ Arthritis/Gout	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Artificial Heart Valve*	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Rheumatism	☐ Yellow Jaundice
☐ Artificial Joint*	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Scarlet Fever	
☐ Asthma	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Shingles	
☐ Breathing Problem	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Sickle Cell Disease	
☐ Bruise Easily	☐ Frequent Headaches	☐ Leukemia	☐ Sinus Trouble	
☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Spina Bifida	
☐ Chemotherapy	☐ Hay Fever	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease	
☐ Chest Pains	☐ Heart Attack/Failure	☐ Lung Disease	☐ Stroke	
☐ Cold Sores/Fever Blisters	☐ Heart Murmur*	☐ Mitral Valve Prolapse*	☐ Swelling of Limbs	

Have you ever had any serious illness not listed above? ○ Yes ○ No Explain: _____

Comments: _____

*Condition may require medication

Dental Information

Do your gums bleed when you brush? Yes __ No __

Are your teeth sensitive to heat or cold? Yes __ No __ Pressure Yes __ No __ Sweets Yes __ No __

Do you grind or clench your teeth? Yes __ No __

Do you have any fear of dental work? Yes __ No __

Date of last dental visit _____ What was done at the time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

To the best of my knowledge, the questions on this 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 my medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

(Over)