Palo Alto Dental Group

Medical & Dental History Information (Confidential)

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.

Name: _____ DOB: _____

Are you under physician's care now? ❑ Yes ❑ No If yes, why? _____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, why? _____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No Explain: _____

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

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

For women: Are you…
- ❑ Pregnant/Trying to get pregnant? ❑ Nursing?
- ❑ Taking oral contraceptives?
- ❑ Taking Bisphosponates (Fosamax), Boniva, Actonel, Zometa, Aclasta? (circle)

Are you allergic to any of the following items?

❑ Aspirin ❑ Amoxicillin/Penicillin ❑ Codeine ❑Local Anesthetics ❑ Acrylic ❑ Metal ❑Latex ❑Other _____

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

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, explain: _____

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

Are your teeth sensitive to hot, cold or 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 that visit? _____

Former Dentist Name _____

Are you experiencing any dental problems currently? _____

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

Have you ever had an unfavorable reaction to previous dental treatment? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service with my informed consent that I may need during diagnosis and treatment.

Signature _____ Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.