PATIENT MEDICAL HISTORY

PATIENT NAME ________________

FAMILY PHYSICIAN & PHONE #: ________________

MEDICAL SPECIALIST *(if any)* & PHONE ________________

DATE OF LAST COMPREHENSIVE MEDICAL EXAM: ________________

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

HEART ATTACK
STROKE
ANGINA
HEART SURGERY
ARTIFICIAL VALVE
PACEMAKER
RHEUMATIC FEVER
HEART MURMUR
ANY OTHER HEART CONDITION
HIGH BLOOD PRESSURE
OTHER CIRCULATORY CONDITION
EMPHYSEMA
TUBERCULOSIS
ASTHMA
OTHER LUNG DISEASE

JAUNDICE
HEPATITIS (TYPE) _______
OTHER LIVER DISEASE
BLOOD TRANSFUSION
ANEMIA
HEMOPHILIA
OTHER BLOOD DISEASE
BRUISE EASILY
DIABETES
KIDNEY DISEASE
EPILEPSY OR SEIZURES
GLAUCOMA
THYROID DISEASE
CANCER/TUMOR

RADIATION THERAPY
CHEMOTHERAPY
ULCER/COLITIS
ARTHRITIS
ARTIFICIAL JOINT OR PROSTHESIS
PHYSCHIATRIC TREATMENT
DRUG/ALCOHOL ADDICTION
TOBACCO HABIT
IV DRUG USE
HIV POSITIVE
FENPHEN OR REDUX FOR WEIGHT LOSS
VENEREAL DISEASE
STOMACH ULCERS
CORTICOSTEROID USE
EATING DISORDER (ANOREXIA NERVOSA, BULEMIA)

PLEASE USE THE SPACE BELOW TO FURTHER DISCUSS ANY MEDICAL TREATMENT OR CONDITIONS, IF NECESSARY ________________

ANY ALLERGY OR SENSITIVITY TO:
☐ PENICILLIN
☐ OTHER ANTIBIOTICS
☐ CODEINE
☐ VALIUM (OR OTHER SEDATIVES)
☐ **LATEX**
☐ LOCAL ANESTHETIC
☐ ASPIRIN

OTHER ALLERGIES ________________

PLEASE LIST ANY DRUGS/MEDICATIONS THAT YOU TAKE, INCLUDING HERBAL/ALTERNATIVE ________________

Women:

Are You Pregnant?	☐ YES	☐ NO	Due Date ________
Are You Planning A Pregnancy In The Near Future?	☐ YES	☐ NO	
Are You A Nursing Mother?	☐ YES	☐ NO	
Are You Taking Birth Control Pills?	☐ YES	☐ NO	

FOR DOCTOR'S USE

DENTAL HISTORY

Former dentist ______________________________ Phone # ____________________

What services are you interested in today? ______________________________

Are you in pain? ☐ YES ☐ NO

Do you sometimes have sores in or around your mouth? ☐ YES ☐ NO

Do you have dental anxiety? ☐ YES ☐ NO

How would you rate your daily oral hygiene regimen? ____________

Approximate date of last dental x-rays ____________________

Have you ever been treated for a TMJ disorder? ☐ YES ☐ NO

Approximate date of last cleaning ____________________

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

Have you ever experienced an adverse reaction to a dental procedure? ☐ YES ☐ NO

Do any children (6 mo. - 16 yrs) in your household regularly consume well-water or bottled water? ☐ YES ☐ NO

Have you ever been treated for periodontal disease? ☐ YES ☐ NO

Are you concerned about bad breath? ☐ YES ☐ NO

Other pertinent information about your dental health or previous treatment. ______________________________

____

____

To the best of my knowledge, all the answers on this form are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform Walker Dentistry at my next appointment.

Signature (Patient, Parent or Guardian) **X** ______________________________ Date ____________________

MEDICAL UPDATES:

DATE: ____________	DATE: ____________	DATE: ____________
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DATE: ____________	DATE: ____________	DATE: ____________
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