# DENTAL PATIENT MEDICAL HISTORY

| NAME *(Last, First, Middle Initial)* | SOCIAL SECURITY NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

| HOME ADDRESS | WORK PHONE | HOME PHONE | EMPLOYER |
|---|---|---|---|
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| WHOM MAY WE THANK FOR REFERRING YOU TO US? | PERSON TO CONTACT IN CASE OF EMERGENCY PHONE |
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| 1. NAME AND ADDRESS OF MEDICAL DOCTOR: PHONE | 2. YEAR LAST MEDICAL PHYSICAL |
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3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

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|---|---|---|---|---|
| Heart Disease or Condition | Rheumatic Fever | Asthma | Hepatitis | Venereal Disease (Syphilis, Gonorrhea) |
| Augina Pecloris | Stroke | Hay Fever | Thyroid Disease | Drug Addiction |
| Frequent Chest Pains | Hemophilia | Emphysema | Glaucoma | Psychiatric Treatment |
| High Blood Pressure | Bruise Easily | Tuberculosis (TB) | Epilepsy or Seizures | Cancer |
| Shortness of Breath | Prolonged or Unusual Bleeding | Diabetes | Fainting or Dizzy Spells | Radiation Therapy |
| Swollen Ankles | Anemia | Ulcers | AIDS or AIDS Related Complex | Chemotherapy |
| Artificial Heart Valve | Blood Transfusion | Kidney Trouble | HIV Positive | Implant Prosthesis |
| Congenital Heart Disease | Sickle Cell Disease | Liver Disease | Cold Sores | Unexplained Weight Loss |
| Heart Murmur | Arthritis | Jaundice (Other than at Birth) | Genital Herpes | |

**CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS.** *(IF IN DOUBT, CIRCLE YES)*
*(IF YES, please give details.)* **CONTINUE COMMENTS ON BACK IF NECESSARY.**

| | | |
|---|---|---|
| 4. ARE YOU PRESENTLY OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR? | **YES** | **NO** |
| 5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS? | **YES** | **NO** |
| 6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS? | **YES** | **NO** |
| 7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC? | **YES** | **NO** |
| 8. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT? | **YES** | **NO** |
| 9. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE? | **YES** | **NO** |
| 10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR? | **YES** | **NO** |
| 11. DO YOU USE TOBACCO IF YES please circle and give frequency)<br>**SMOKE:** Cigarettes Cigar Pipe **SMOKELESS:** Chewing Tobacco Snuff or "Dip" **FREQUENCY:** | **YES** | **NO** |

12. **WOMEN:** ARE YOU PREGNANT? (If YES, please circle trimester block) **YES** | **NO** **TRIMESTER** 1 | 2 | 3

I hereby grant authority to Dr. Steven W. Haywood to administer any treatment agreed upon; or to administer such anesthetics and to perform such operations as may be deemed necessary or advisable in a diagnosis and treatment of this patient.

| **PATIENT COMMENTS** (Check this box if you have additional comments on the back of this form) ☐ | **SIGNATURE OF PATIENT** (or legal guardian if patient is a minor)<br>X | **DATE**<br>X |
|---|---|---|

**DENTIST'S COMMENTS**

| **DENTIST'S SIGNATURE** | **DATE** | **REVIEWER** | **DATE** | **REVIEWER** | **DATE** | **REVIEWER** | **DATE** |
|---|---|---|---|---|---|---|---|
| | | | | | | | |