Almond Dental
Comprehensive, compassionate care.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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.

Patient Name: ____ **Birth date**: ________________

Are you under the care of a physician now? ( ) Yes ( ) No   Have you ever had a serious Head or Neck injury? ( ) Yes ( ) No

Do you use tobacco products? ( ) Yes ( ) No   Do you use controlled substances? ( ) Yes ( ) No

Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No_____________________________________

Are you taking any medications, pills, and or drugs? (Please list)

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Do you require a premedication BEFORE dental treatment? ( ) Yes ( ) No If yes, what do you normally take?__________

Do you take aspirin daily or any other kind of blood thinner? ____

Are you allergic to any of the following?

Aspirin___ Penicillin ___ Codeine___ Acrylic___ Metal___ Latex___ Local Anesthetics___

Other____

Women:

Are you pregnant? ( ) yes ( ) no   If yes when is your estimated due date? __________

Are you nursing? ( ) yes ( ) no   Are you taking oral contraceptives? ( ) yes ( ) no (some medications may interfere)

AIDS/HIV	( ) Yes	( ) No	Emphysema	( ) Yes	( ) No	Low Blood Pressure	( ) Yes	( ) No
Alzheimers	( ) Yes	( ) No	Epilepsy or Seizures	( ) Yes	( ) No	Lung Disease	( ) Yes	( ) No
Anaphylaxis	( ) Yes	( ) No	Excessive Bleeding	( ) Yes	( ) No	Mitral Valve Prolapse	( ) Yes	( ) No
Anemia	( ) Yes	( ) No	Excessive Thirst	( ) Yes	( ) No	Osteoporosis	( ) Yes	( ) No
Angina	( ) Yes	( ) No	Frequent headaches	( ) Yes	( ) No	Pain in Jaw Joints	( ) Yes	( ) No
Arthritis/Gout	( ) Yes	( ) No	Faint/Dizziness	( ) Yes	( ) No	Psychiatric Care	( ) Yes	( ) No
Artificial Valve	( ) Yes	( ) No	Glaucoma	( ) Yes	( ) No	Radiation Treatment	( ) Yes	( ) No
Artificial Joint	( ) Yes	( ) No	Heart Attack/Failure	( ) Yes	( ) No	Renal Dialysis	( ) Yes	( ) No
Acid Reflux	( ) Yes	( ) No	Heart Murmur	( ) Yes	( ) No	Rheumatic Fever	( ) Yes	( ) No
Asthma	( ) Yes	( ) No	Heart Pace Maker	( ) Yes	( ) No	Sinus Trouble	( ) Yes	( ) No
Blood Disease	( ) Yes	( ) No	Heart Disease	( ) Yes	( ) No	Stomach/intestinal Disease	( ) Yes	( ) No
Blood Transfusion	( ) Yes	( ) No	Hepatitis ( ) A ( )B	( ) C	( ) No	Swelling of Limbs	( ) Yes	( ) No
Breathing Problems	( ) Yes	( ) No	High Blood Pressure	( ) Yes	( ) No	Thyroid Disease	( ) Yes	( ) No
Cancer	( ) Yes	( ) No	High Cholesterol	( ) Yes	( ) No	Tonsillitis	( ) Yes	( ) No
Chemotherapy	( ) Yes	( ) No	Hypoglycemia	( ) Yes	( ) No	Tuberculosis	( ) Yes	( ) No
Chest Pains	( ) Yes	( ) No	Kidney Problems	( ) Yes	( ) No	Tumors	( ) Yes	( ) No
Cold Sores/blisters	( ) Yes	( ) No	Stroke when?_______	( ) Yes	( ) No	Ulcers	( ) Yes	( ) No
Congenital Heart Disor	( ) Yes	( ) No	Leukemia	( ) Yes	( ) No	Take Cortisone	( ) Yes	( ) No
Diabetes	( ) Yes	( ) No	Liver Disease	( ) Yes	( ) No	Yellow Jaundice	( ) Yes	( ) No
Drug Addiction	( ) Yes	( ) No						

Have you ever had any serious illness not listed above? ____

Comments:____

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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 patients) health. It is my responsibility to inform Almond Dental of any changes in medical status.

Signature of Patient, Parent, or Guardian______________________________________ Date_____________________