Patient Medical History **Patient Name**_________________________

Are you ALLERGIC to, or have you had, any REACTIONS to the following? (**please check Yes or No**)

Y N
- □□ Penicillin, Amoxicillin
- □□ Clindamycin, Keflex, Cipro, Erythromycin
- □□ Dental Anesthetics
- □□ Metals (i.e. nickel, silver, gold, platinum, titanium)
- □□ Barbituates, Sedatives (i.e. halcion, valium)
- □□ Other (drugs or foods)____

Y N
- □□ Codeine or Other Pain Prescriptions
- □□ Aspirin (Advil), Ibuprofen, Acetaminophen (Tylenol)
- □□ Latex or Rubber Products
- □□ Sulfa Drugs or Iodine
- □□ Steroids or Cortisone

Are you taking any naturopathic (holistic) remedies, vitamins or herbal supplements? ___________________
Do you regularly take Rx blood thinners? ______________ Aspirin, Motrin, or Advil?______________
Do you use controlled substances? ______________ Do you use tobacco or smoke?______________
Are you under medical treatment now? ______________________________
Have you been hospitalized for surgery or illness recently? ______________________
Have you had joint replacement surgery? ________ What? ____________ When? ____________
Has your physician or dentist suggested you be pre-medicated for dental work? _______ What Rx? ____________
List any other prescription and non-prescription drugs you are regularly taking____________________
____
List all current Physicians____

Women Only: Are you pregnant or think you may be pregnant? ______________ Approx Due Date ________
Are you nursing? ____________ Are you taking oral contraceptives? ____________________

Do you have, or have you ever had any of the following? (**please check Yes or No**)

Y N	Y N	Y N	Y N
□□ Heart Attack	□□ High Blood Pressure	□□ Radiation Therapy	□□ Sexually Transmitted Disease
□□ Heart Trouble	□□ Low Blood Pressure	□□ Chemotherapy	□□ AIDS or HIV Infection
□□ Angina/Chest Pain	□□ Prolonged Bleeding	□□ Arthritis	□□ Hepatitis
□□ Pacemaker	□□ Anemia	□□ Steroids/Cortisone	□□ Jaundice
□□ Mitral Valve Prolapse	□□ Diabetes	□□ Respiratory Problems	□□ Fever Blisters, Herpes, Shingles
□□ Artificial Heart Valve	□□ Liver Disease	□□ Asthma	□□ Hay Fever, Allergies
□□ Heart Murmur	□□ Kidney Disease	□□ Emphysema	□□ Fainting, Seizures
□□ Rheumatic Fever	□□ Thyroid Problem	□□ Tuberculosis	□□ Stomach Troubles, Ulcers
□□ Stroke	□□ Cancer____________	□□ Artificial Joint	□□ Epilepsy, Convulsions
□□ Glaucoma	Other______________________		

SOUTH VALLEY DENTISTRY

Patient Dental History

Name of previous Dentist________________________ Location______________ Last Exam________

Do your gums bleed while brushing or flossing?__________
Are your teeth sensitive to hot/cold liquids/foods? __________
Are your teeth sensitive to sweet/sour liquids/foods?__________
Have you had any head, neck or jaw injuries?__________
Have you considered bleaching your teeth?__________
Have you bleached your teeth in the past? __________
Are you happy with your smile? __________
Have you considered replacing your silver fillings? __________

Have you had any orthodontic treatment?______When?_______
Do you wear dentures or partials?______How long? _________
Do you feel pain/discomfort in any teeth? _____Where?_______
Do you have a dry mouth?__________
Have you experienced problems or pain in your jaw?__________
Do you have frequent headaches? __________
Do you clench or grind your teeth? __________
Do you wear/have you worn a nightguard? __________

Do you know/want to know about dental procedures available to improve your smile? ____________________

Patient Health Responsibilities

I have read and understand the above information to the best of my knowledge and realize that providing incorrect information can be dangerous to my health. I certify that the above questions have been accurately answered.

In order to achieve optimum results, a cooperative effort is required. Once a treatment plan has been established, it is the patient's responsibility to follow instructions provided involving follow up care and appointments. A mutual respect and consideration among the Doctors, patients and staff is required to achieve our common goals.

Patient/Guardian Signature______________________________ **Date**______________

Reviewed by Doctor ______________________________ **Date** ______________