

Hillcrest Family Dentistry's Medical History

Patient Name:

Birth Date:

Date Created:

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, c

Health Information

Are you in good health? Has there been any change in your general health within the past year? When was your last physical exam? Physician's Name and Phone # Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs (including non prescription)? Have you ever taken Fosamax, Boniva, Actonel or any other medications for osteoporosis? Are you on a special diet? Do you use tobacco (smoke cigarettes, pipe, marijuana or chew)?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Metal Barbiturates, Sedatives or Sleeping Pill Penicillin Latex Iodine Codeine Sulfa Drugs Narcotics Acrylic Local Anesthetics Other? If yes

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? Have you had any serious trouble associated with any previous dental treatment? including anesthetics?

SMILE QUESTIONS

Do you like your smile? Would you change anything about your smile? Would you like whiter teeth? Would you like straighter teeth?

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: