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GENERAL DENTISTRY

## MEDICAL HISTORY

Patient \_\_\_\_\_ Date \_\_\_\_\_

1. Are you allergic to: Penicillin\_\_\_ Novocaine \_\_\_ Aspirin \_\_\_ Codeine\_\_\_ Any other drug\_\_\_\_\_
2. Are you presently taking any drugs or medications? Yes No If so, What?\_\_\_\_\_
3. Do you need pre-medication for dental procedures? \_\_\_\_\_ If YES, for what condition? \_\_\_\_\_
4. Are you presently under the care of a physician? Yes No If YES, for what condition?\_\_\_\_\_
5. If you answered YES to question #4, Physicians name and number? \_\_\_\_\_
6. Have you ever been hospitalized (except for pregnancy)? \_\_\_\_\_
7. Have you ever had major surgery? \_\_\_\_\_ Are you Pregnant? \_\_\_\_\_
8. Do you have or have you had any of the following diseases or problems:

Yes No

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur or Rheumatic Heart Disease   |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease or Syphilis  |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia or Blood Disorder  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Hay Fever   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular disease (heart trouble, high or low blood pressure, Arteriosclerosis, or Stroke) |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcers  |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis  |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous Condition   |
| <input type="checkbox"/> | <input type="checkbox"/> | Goiter or Thyroid Disorder  |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions or Epilepsy   |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Trouble  |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Tendencies   |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS or AIDS Related Disease  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you or are you taking Phen/ Fen  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, Jaundice or Liver Disease  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer  |
| <input type="checkbox"/> | <input type="checkbox"/> | Treated with Radiation or Chemotherapy  |

## DENTAL HISTORY

1. Nature of present dental problem \_\_\_\_\_
2. Are you fearful of Dentistry? No \_\_\_\_\_ A Little \_\_\_\_\_ A Lot \_\_\_\_\_ Totally \_\_\_\_\_
3. What is the worst part of dental treatments? \_\_\_\_\_
4. Have you had any serious trouble associated with any previous dental treatment ? \_\_\_\_\_  
If so, explain \_\_\_\_\_
5. Last visit to a dentist \_\_\_\_\_
6. Dentist's name and address \_\_\_\_\_
7. Are you on Gwinnett County Water \_\_\_\_\_ Well Water \_\_\_\_\_ Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_