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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	
☐	☐	Heart Murmur, Rheumatic Heart Disease, or Infective Endocarditis
☐	☐	Venereal Disease or Syphilis
☐	☐	Anemia or Blood Disorder
☐	☐	Asthma or Hay Fever
☐	☐	Diabetes
☐	☐	Arthritis
☐	☐	Cardiovascular disease (heart trouble, high or low blood pressure, Arteriosclerosis, or Stroke)
☐	☐	Stomach Ulcers
☐	☐	Tuberculosis
☐	☐	Nervous Condition
☐	☐	Goiter or Thyroid Disorder
☐	☐	Convulsions or Epilepsy
☐	☐	Kidney Trouble
☐	☐	Bleeding Tendencies
☐	☐	AIDS or AIDS Related Disease
☐	☐	Have you or are you taking Phen/ Fen
☐	☐	Hepatitis, Jaundice or Liver Disease
☐	☐	Cancer
☐	☐	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**_____