

AIDC DENTAL PATIENT MEDICAL HISTORY

Please answer all questions. Sign and date at the bottom of the page.
If you are unsure of how to answer any of the following questions, please ask the dental staff for help.

How did you find out about this dental clinic? _____

What is the reason for your visit to the dental clinic? _____

What is the name of your medical doctor? _____

What is the date of your last medical appointment? _____

Has there been any change in your general health this year? Yes _____ No _____ Explain: _____

List any medications you currently take (including those you may have purchased without a prescription and/or any herbal remedies that you take): _____

Patient General Health: Good Fair Poor Gender: Male Female

Please check your answers	YES	NO	Have you ever had any of the following	YES	NO
1. Do you have a toothache?			1. Hepatitis What kind? A B C Other Treated or Active? (circle one)		
2. Have you received medical care within the past two years? Why/When?			2. Heart murmur		
3. Have you ever been hospitalized? Why/When?			3. Heart attack or heart trouble		
4. Have you taken medications in the last 2 months? What?			4. High blood pressure		
			5. Rheumatic fever		
5. Are you allergic to or made sick by any medicine such as penicillin, aspirin, codeine, or sulfur? Other?			6. Heart valve or pace maker, heart surgery If yes, does the patient require medication for dental appointments?		
			7. Artificial joint		
6. Are you allergic to latex, iodine, red dye, metal and/or local anesthetic?			8. Anemia		
			9. Stroke		
7. Have you ever had a bleeding problem that needed medical treatment?			10. Ulcers		
			11. Liver problems		
8. Do you have chest pain?			12. TB or lung disease Treated or Active? (circle one)		
9. Do you use alcohol or drugs?			13. Asthma		
10. Do you use tobacco products?			14. Sinus trouble		
11. Do you have reason to believe you might have HIV/AIDS or herpes?			15. Epilepsy or seizures		
			16. Cancer or tumor Chemotherapy and/or radiation dates?		
12. Diabetes? Type 1 or Type 2 (circle one)			17. Arthritis / Rheumatism (including juvenile)		
13. Does anyone in your family have diabetes? Who? (mom, dad)			18. Lupus		
			19. Blood transfusion, hemophilia		
14. Do you play sports?			20. Sexually transmitted disease		
15. Do you have concerns about receiving dental treatments? Explain:			21. Kidney problems/dialysis		
			22. Nervous or mental disorder, emotional problems, hyperactivity		
16. Do you have any physical or mental disability that requires special considerations? Explain:			23. Osteoporosis If yes, do you take any medication?		
			24. Do you have any condition not listed? Explain:		
17. Females only Taking birth control? Pregnant? Currently breastfeeding?					

PATIENT IDENTIFICATION	<p>The answers I have given are true to the best of my knowledge. I am giving my consent for routine dental procedures such as X-rays, cleaning, fillings, crowns and/or local anesthesia by signing below:</p> <p>_____</p> <p>Patient signature (or Parent/Guardian if patient is a minor) Date</p> <p>_____</p> <p>Dentist signature Date</p>
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