MOUNTAIN SHADOWS FAMILY DENTAL

21765 W. Yuma Rd Ste. 101
Buckeye, AZ 85326
623-691-6300

MEDICAL HISTORY

Patient Name: _____ **Date of Birth**: _____

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes, for what reason? _____
2. List all medication you are taking at this time: _____
   _____
   _____
3. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? If so, list ☐ Yes ☐ No
   _____
4. Are you a smoker? ☐ Yes ☐ No
5. Do you use or have you ever used recreational drugs? ☐ Yes ☐ No
6. ***Women:*** Are you pregnant ☐ Yes ☐ No If yes, due date: _____
7. Check any of the following which you have had or have at present:

☐ Arthritis	☐ Glaucoma	☐ Liver Disease
☐ Artificial Heart Valve	☐ Heart Disease or Attack	☐ Nervousness/Anxiety
☐ Artificial Joint	☐ Heart Pacemaker	☐ Pain in Jaw Joints
☐ Asthma	☐ Heart Murmur/Mitral Valve	☐ Psychiatric Treatment
☐ Cancer/Chemotherapy	☐ Hemophilia	☐ Rheumatic Fever
☐ Cold Sores/Fever Blister	☐ Hepatitis A/B	☐ Shortness of Breath
☐ Diabetes	☐ High Blood Pressure	☐ Stroke
☐ Drug Addiction	☐ HIV/AIDS	☐ Thyroid Disease
☐ Epilepsy/Seizures	☐ Kidney Trouble	☐ Tuberculosis(TB)

☐ Do you have any disease, condition or problem not listed? If so, please list…….. ☐ Yes ☐ No
_____
_____

DENTAL HISTORY

1. Are you having dental problems at this time? ☐ Yes ☐ No
2. Do your gums bleed or feel tender or swollen at any time? ☐ Yes ☐ No
3. Do you clench or grind your teeth? ☐ Yes ☐ No
4. Are your teeth sensitive to hot, cold, sweets or chewing? ☐ Yes ☐ No
5. Please describe any dental concerns you have: _____
   _____

Consent: To the best of my knowledge, the above information on this Health History sheet is as complete and as accurate as possible. I understand that without full and accurate information, the Doctor may not be able to provide me with the best care possible. I hereby authorize the Doctor to take radiographs (x-rays), study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs.

Signature of Patient/Guardian _____ **Date:** _____