MOUNTAIN SHADOWS FAMILY DENTAL

## 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:** _____