Chico Dental Care

MEDICAL HISTORY

Patient Name_____

Have you ever had or do you currently have any of the following?

AIDS	❒Yes	❒No	Jaw Pain	❒Yes	❒No	**Have you ever had or do you currently have any of the following?**		
Anemia	❒Yes	❒No	Kidney Disease	❒Yes	❒No	Artificial Heart Valves	❒Yes	❒No
Arthritis	❒Yes	❒No	Liver Disease	❒Yes	❒No	Artificial Joints, Screws or Pins	❒Yes	❒No
Asthma	❒Yes	❒No	Low Blood Pressure	❒Yes	❒No	Bleeding Abnormally, with Extractions or Surgery	❒Yes	❒No
Back Problems	❒Yes	❒No	Nervous Problems	❒Yes	❒No			
Cancer	❒Yes	❒No	Psychiatric Care	❒Yes	❒No	Blood Disease	❒Yes	❒No
Chemical Dependency	❒Yes	❒No	Radiation Treatment	❒Yes	❒No	Congenital Heart Lesions	❒Yes	❒No
Chemotherapy	❒Yes	❒No	Respiratory Disease	❒Yes	❒No		❒Yes	❒No
Circulatory Problems	❒Yes	❒No	Scarlet Fever	❒Yes	❒No			
Cortisone Treatments	❒Yes	❒No	Shortness of Breath	❒Yes	❒No	**Are you allergic to any of the following?**		
Cough, Persistent or Bloody	❒Yes	❒No	Sinus Trouble	❒Yes	❒No			
Diabetes	❒Yes	❒No	Skin Rash	❒Yes	❒No	Aspirin		
Emphysema	❒Yes	❒No	Special Diet/Weight Loss	❒Yes	❒No	Barbiturates	❒Yes	❒No
Epilepsy	❒Yes	❒No	Stroke	❒Yes	❒No	Codeine	❒Yes	❒No
Fainting or Dizziness	❒Yes	❒No	Swollen Feet or Ankles	❒Yes	❒No	Ibuprophen	❒Yes	❒No
Glaucoma	❒Yes	❒No	Swollen Neck Glands	❒Yes	❒No	Latex	❒Yes	❒No
Herpes	❒Yes	❒No	Thyroid Problems	❒Yes	❒No	Local Anesthesia	❒Yes	❒No
Heart Problems	❒Yes	❒No	Tobacco Use	❒Yes	❒No	Metals	❒Yes	❒No
Hepatitis Type ___	❒Yes	❒No	Tonsillitis	❒Yes	❒No	Penicillin	❒Yes	❒No
Headaches	❒Yes	❒No	Tumors or Growths	❒Yes	❒No	**Other Allergies:**	❒Yes	❒No
High Blood Pressure	❒Yes	❒No	Tuberculosis	❒Yes	❒No	(Please list below)	❒Yes	❒No
HIV Positive	❒Yes	❒No	Ulcer	❒Yes	❒No			
Jaundice	❒Yes	❒No						

Have you ever had complications following dental treatment? ❒Yes ❒No

If yes, please describe: _____

_____

_____

_____

_____

_____

Women: Are you pregnant? ❒Yes ❒No

Due Date_____

Are You Nursing? ❒Yes ❒No

Taking Birth Control Pills? ❒Yes ❒No

Are you currently taking any blood thinners such as Coumadin, Warfarin, Plavix, aspirin, etc.? ❒Yes ❒No

If yes, please list which of these meds you have taken/are taking below:

_____

Have you ever taken or are you currently taking any bone density medications (bisphosphonates) such as Actonel, Boniva, Fosamax, Zometa, etc.? ❒Yes ❒No

If yes, please list which of these meds you have taken/are taking below:

_____

Please print all medications you are currently taking_____

_____

_____

_____

_____

_____

Have you ever been hospitalized or do you have any other health concerns? ❒Yes ❒No

If yes, please explain:

_____

_____

_____

_____

I hereby consent to an examination, x-rays, study models, photographs and any other procedures that the doctor deems necessary for a complete and thorough evaluation of my dental health.

Signature of Patient or Parent/Guardian _____ **Date** _____

Doctor Signature _____ Date _____

Patient Signature_____ Doctor Signature_____ Recall Date_____

Patient Signature_____ Doctor Signature_____ Recall Date_____

Patient Signature_____ Doctor Signature_____ Recall Date_____

Patient Signature_____ Doctor Signature_____ Recall Date_____