DORRI'S DENTAL

MEDICAL HISTORY

Patient

Last Name: _____ , First Name: _____ , Middle Name: _____

Medical History

Physician's Name: _____ , Date of last visit: _____

Are you currently under the care of a physician? If yes, for what? _____

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever taken Bisphosphonates (IV or Oral)? If yes, please list type and dates taken: _____

_____

Have you ever had head or neck radiation therapy? ☐ Yes ☐ No

Are you taking any blood thinners? If yes, which one(s) _____

List all medications you are taking: _____

Are you allergic to: ☐ Penicillin ☐ Clindamycin ☐ Sulfa Drugs ☐ Codeine ☐ Latex

Other Allergy? _____

Women Only

Are you pregnant? ☐ Yes ☐ No , Due Date: _____ , Nursing? ☐ Yes ☐ No , Taking Birth Control: ☐ Yes ☐ No

Please check if you have/had

Allergies, hay fever, sinusitis: ☐ Yes ☐ No , Emphysema: ☐ Yes ☐ No , Pacemaker: ☐ Yes ☐ No

Anemia: ☐ Yes ☐ No , Epilepsy: ☐ Yes ☐ No , Respiratory disease: ☐ Yes ☐ No

Arthritis, Rheumatism: ☐ Yes ☐ No , Fainting: ☐ Yes ☐ No , Rheumatic fever: ☐ Yes ☐ No

Artificial heart valve(s): ☐ Yes ☐ No , Headaches: ☐ Yes ☐ No , Shortness of breath: ☐ Yes ☐ No

Artificial joint (s): ☐ Yes ☐ No , Heart Murmur: ☐ Yes ☐ No , Sickle Cell Anemia: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No , Heart Problems: ☐ Yes ☐ No , Sinus trouble: ☐ Yes ☐ No

Bleeding abnormally with surgery: ☐ Yes ☐ No , Hepatitis type: ☐ Yes ☐ No , Stroke: ☐ Yes ☐ No

Blood disease, clotting disorders: ☐ Yes ☐ No , Herpes: ☐ Yes ☐ No , Slow healing wounds: ☐ Yes ☐ No

Cancer: ☐ Yes ☐ No , High blood pressure: ☐ Yes ☐ No , Swelling of ankles/feet: ☐ Yes ☐ No

Chemical dependency: ☐ Yes ☐ No , Immune deficiency: ☐ Yes ☐ No , Thyroid problems: ☐ Yes ☐ No

Chemotherapy: ☐ Yes ☐ No , Jaundice: ☐ Yes ☐ No , Tonsillitis: ☐ Yes ☐ No

Circulatory problems: ☐ Yes ☐ No , Kidney disease: ☐ Yes ☐ No , Tuberculosis: ☐ Yes ☐ No

Long term cortisone/steroid use: ☐ Yes ☐ No , Low blood pressure: ☐ Yes ☐ No , Tumor or growths: ☐ Yes ☐ No

Cough, persistent: ☐ Yes ☐ No , Mitral Valve prolapse: ☐ Yes ☐ No , Ulcers: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No , Osteoporosis/osteopenia: ☐ Yes ☐ No, Venereal Disease: ☐ Yes ☐ No

Any other condition(s) not listed above: _____

DENTAL HISTORY

Date of last dental visit/x-rays: _____

Have you had an allergic reaction to local or general anesthetics? ☐ Yes ☐ No

Have you ever had trouble with/from prior dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

What are your main concerns about your smile? _____

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