MEDICAL HISTORY

Reason for today's visit: ☐Cleaning/Exam ☐Emergency ☐Are you in pain now? If so, where?_____

Are you experiencing any of these problems?

☐ Red, swollen or bleeding gums	☐ Sensitive Teeth	☐ Stained Teeth
☐ Teeth Grinding	☐ Blisters/Sores in Mouth	☐ Bad Breath
☐ Painful Jaw	☐ Broken/Chipped tooth	

Do you need pre-medication before your dental appointment? ☐Yes ☐No ☐Don't Know

How many times a day do you brush?____ How many times a week do you floss?___

What medications are you taking? ☐Blood Thinners ☐Nerve Pills ☐Pain killers ☐Tranquilizers ☐Stimulants ☐Muscle Relaxers ☐Insulin ☐Birth control ☐Osteoporosis Medication

Have you ever taken: BISPHSPHONATES (e.g. ACTONEL, AREDIA, BONIVA, FOSAMAX, PROLIA, RECLAST) ☐Yes ☐No

Please list all other medications:_____

***CIRCLE** if you currently have or previously had any of the following medical conditions :

ALCOHOL/DRUG ABUSE	EMPHYSEMA/COPD	NECK PAIN/SWOLLEN GLANDS
ANEMIA	EPILEPSY	NERVOUS DISORDERS
ARTIFICIAL JOINTS/BONES	FAINTING	OSTEOPOROSIS
ARTIFICIAL VALVES	FREQUENT HEADACHES	PACEMAKER
ARTHRITIS/RHEUMATISM	GLAUCOMA	PSYCHIATRIC DISORDERS
ASTHMA	HEART ATTACK	RADIATION/COBALT TREATMENT
BACK PROBLEMS	HEART DISEASE	RHEUMATIC FEVER
BLEEDING PROBLEMS	HEART MURMUR	SCARLET FEVER
BRITTLE BONES	HEART SURGERY	SEIZURES
CANCER/TUMORS	HEPATITIS	SHINGLES
CHEMOTHERAPY	HIGH/LOW BLOOD PRESSURE	SINUS PROBLEMS
CHEST PAINS	HIV/AIDS/ARC	STOMACH PROBLEMS/ULCERS
CHOLESTEROL PROBLEMS	JAW PROBLEMS (TMJ/TMD)	STROKE
CONGENITAL HEART DEFECT	KIDNEY PROBLEMS	THYROID DISEASE
COSMETIC SURGERY	LEUKEMIA	TUBERCULOSIS (tb)
DIABETES	LIVER PROBLEMS/CHANGES	VENEREAL DISEASE
DIFFICULTY BREATHING	MITRAL VALVE PROLAPSE	

ALLERGIES

Are you allergic to any of the following: ☐Latex ☐Penicillin/Amoxicillin ☐Tetracycline ☐Aspirin ☐Erythromycin ☐Codeine ☐Dental Anesthetics ☐Food Others_____

Do you use tobacco? ☐No ☐Yes/what type?_____How much?_____How long?_____

Are you pregnant? ☐No ☐Yes/how far along_____Are you nursing? ☐No ☐Yes

Have you ever had a serious/difficult problem associated with any previous dental procedures? ☐ No ☐Yes

CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Decatur Dental Services, Inc. is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA

Thank you for completing this form in its entirety. It will enable us to serve you more effectively.