Patient's Name: _____ ***Age:*** _____

Physician's Name: _____ ***Phone Number:*** _____***Date of last exam:***_____

Last time you were hospitalized? Date: _____ ***Reason:*** _____

Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible health care to you (or your child or dependent), please provide the following information. HAVE YOU EVER HAD OR HAVE…?

(Please circle)…MEDICAL HISTORY... THE DENTIST'S HOUSE OF EDINA

y n Asthma, hay fever or sinusitis *and if yes, specify Medication:* _____

y n Tuberculosis or Breathing Problems…

y n ALLERGIC REACTION TO ANY MEDICATIONS (DRUGS)
(I.e.) Penicillin, Novocain, Aspirin, or specify: _____

y n High Blood Pressure *and if yes, specify Medications:* _____

y n Rheumatic Fever, Heart Murmur or Heart Problems…

y n Prosthetic Heart Valve or any Prosthetic Device in your body, *if yes, Date:* _____

y n Antibiotics before a Dental or Surgical Procedure…

y n Diabetes, Liver, Kidney, or Thyroid Problems…

y n Ulcers or Stomach Problems *and if yes, specify Medications:* _____

y n Hepatitis or Jaundice *and if yes, Date:* _____ ***Results:*** _____

y n Epilepsy or Nervous Disorders *and if yes, specify Medication:* _____

y n Bleeding or Clotting disorders: Do your wounds heal slowly or present complications? y n

y n Arthritis *and if yes, specify Medications:* _____

y n Acquired Immune Deficiency Syndrome (AIDS) or HIV Positive…

y n Venereal Disease or Herpes…

y n SPECIFY ANY MEDICATIONS NOT MENTIONED *(or please provide us with a list of medications):*
_____

y n Have you had or having Radiation, Steroid Treatment or Chemotherapy… *Date:* _____

y n Are you presently on a Diet…

y n Do you use tobacco… ( ) Cigarettes ( )Pipe ( ) Cigar ( ) Smokeless Tobacco

y n Do you use controlled substances…

y n Do you wear contact lenses…

y n Are you presently on a diet…

Women: ( ) Are you on birth control pills? ( ) Are you pregnant or any possibility?

(over please)

Please circle) ***...DENTAL HISTORY...*** ***THE DENTIST'S HOUSE OF EDINA***

y n Have you had trouble from previous dental care? Please specify: _____

y n Any of the below jaw experiences…
- *y n injury, location: _____*
- *y n clicking*
- *y n pain: ( ) joint, ( ) ear, ( ) side of face…*
- *y n difficulty in opening…*
- *y n difficulty in chewing…*

y n Do you have any unhealed injuries, growths, or sore spots in or around your mouth…

y n Do you have bleeding gums…

y n Are your teeth sensitive to cold…

y n Have you had any head or neck injuries…

y n Frequent headaches…

y n Clench or grind your teeth…

y n Bite your lip or tongue…

y n Difficulty with extractions…

y n Are you HAPPY with the way your teeth look?

y n Are you SATISFIED with the way you chew your food?

Are there any other problems not covered above that you would like to discuss? _____
_____
_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient (or Legal Guardian) Signature: _____ Date: _____
(Update) Signature: _____ Date: _____
(Update) Signature: _____ Date: _____
(Update) Signature: _____ Date: _____
(Update) Signature: _____ Date: _____

Reviewed: Date: _____ Hyg.'s/Dr.'s Initials _____ Date: _____ Hyg.'s/Dr.'s Initials _____
_____ Hyg.'s/Dr.'s Initials _____ _____ Hyg.'s/Dr.'s Initials _____
_____ Hyg.'s/Dr.'s Initials _____ _____ Hyg.'s/Dr.'s Initials _____

THANK YOU