Artistic Dentistry Medical History

Patient Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ Physician Phone #: _____

Do you have any allergies to the medications/materials listed?

YES	**NO**	Aspirin	**YES**	**NO**	Penicillin
YES	**NO**	Codeine	**YES**	**NO**	Sulfa
YES	**NO**	Latex	**YES**	**NO**	Morphine
YES	**NO**	Local Anesthetic	**YES**	**NO**	Clindamycin/Erythromycin

Please write any allergies not listed above: _____

Please circle YES or NO for *each item* that you have now or have had before:

YES	**NO**	High Blood Pressure	**YES**	**NO**	Arthritis/Gout	**YES**	**NO**	Epilepsy / Seizures
YES	**NO**	Low Blood Pressure	**YES**	**NO**	Artificial Joint / Bone	**YES**	**NO**	Fainting / Dizziness
YES	**NO**	AIDS/HIV Positive	**YES**	**NO**	Asthma	**YES**	**NO**	Frequent Headaches
YES	**NO**	Anemia	**YES**	**NO**	Cancer _____	**YES**	**NO**	Hepatitis Type____
YES	**NO**	Abnormal Bleeding	**YES**	**NO**	Chemo / Radiation	**YES**	**NO**	Herpes
YES	**NO**	Heart Valves (Artificial)	**YES**	**NO**	Diabetes	**YES**	**NO**	Kidney Problems
YES	**NO**	Blood Disease	**YES**	**NO**	Emphysema	**YES**	**NO**	Liver Disease
YES	**NO**	Congenital Heart Lesions	**YES**	**NO**	Glaucoma	**YES**	**NO**	Nervous Problems
YES	**NO**	Heart Pacemaker	**YES**	**NO**	Shortness of Breath	**YES**	**NO**	Psychiatric Care
			YES	**NO**	Sinus Problems			
YES	**NO**	Smoke/Use Tobacco	**YES**	**NO**	Stroke	**Are you Currently:**		
YES	**NO**	Drink Alcohol	**YES**	**NO**	Thyroid Problems	**YES**	**NO**	Pregnant
YES	**NO**	High Sugar Intake	**YES**	**NO**	Tuberculosis	**YES**	**NO**	Nursing
			YES	**NO**	Ulcers			

Please write any medical conditions not listed above: _____

Please List ALL **Medications/Supplements** you currently take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you taking or have you ever taken Bone Density Medications? YES NO

If Yes, enter medication name and dates of use? _____

Have you been hospitalized within the last 3 years?

YES **NO** If Yes, state reason for hospitalization: _____

_____

Do you wear dentures or partials? YES NO Upper - How Long? _____ Lower - How Long? _____

Have you had regular dental care? YES NO Date of Last Visit to Dentist? _____

Do you have dental pain / problems today? YES NO Please Describe: _____

Please inform us of any special needs during dental treatment: _____

I have responded to the above information and to the best of my ability. I understand providing incorrect information can be dangerous to my health. I will notify this office of any changes in my health or medications.

Patient Signature _____ Date _____