Meadow Vista Dental Care

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MEDICAL/DENTAL HISTORY

Patient Name _____

Name of previous dentist _____

Date of:_____ last cleaning _____last treatment_____ last full mouth x-rays

Approximate date of last physical exam_____ Name of your physician _____

YES NO Are you currently under medical treatment?

YES NO Do you now have or have you ever had any of the following?

YES NO A heart ailment

YES NO High blood pressure

YES NO A lung disease

YES NO Diabetes

YES NO Rheumatic fever

YES NO Tumors or growths

YES NO Any blood disease

YES NO Hepatitis or any liver disease

YES NO Any kidney disease

YES NO Stomach or intestinal disease

YES NO Prolonged bleeding following any injury or surgery

YES NO Chest pain or angina pectoris

YES NO AIDS or antibodies to the AIDS virus

YES NO Have you had any major operations?

YES NO Have you ever had a serious accident involving head injuries?

YES NO Are you currently allergic to or have reactions such a hives, rash or asthma to:

Latex rubber _____ Any other known substance_____

YES NO Are you currently taking any drugs or medications? List here- if you need additional space please attach separate sheet.

YES NO Are you an any special kind of diet?

YES NO Do you have any history of fainting or convulsions?

YES NO Have you ever had radiation therapy?

YES NO Have you ever had any adverse reaction to any drugs, such as Penicillin?

YES NO *For women patients*: Are you currently pregnant? (If so, due date)_____ Nursing?___ Taking oral contraceptives?_____

YES NO Have you ever had a problem with addiction to: Alcohol_____ Drugs (if yes, please specify)_____

YES NO Do you smoke? If so, are you quitting?_____

Is there anything of importance regarding your medical history that has not been asked, if so please explain

_____

Signature_____Date_____