Patient's Name: ____ Age: ____________ Birth date: ___/___/____

MEDICAL HISTORY

Your CURENT physical health is ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ No ☐ Yes
Please explain (if answer is yes) ____
Are you taking any prescription / over the counter drugs? ☐ No ☐ Yes
Please list each one ____

FOR WOMEN

Are you taking birth control pills? ☐ No ☐ Yes
Are you pregnant? ☐ No ☐ Yes (week # _____)

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

☐ Heart Attack / Stroke
☐ Cancer / Chemotherapy
☐ Heart Murmur
☐ Rheumatic Fever
☐ HIV + AIDS
☐ Heart Surgery / Pacemaker
☐ Mitral Valve Prolapse
☐ Artificial Bones / Joints
☐ Artificial Valves
☐ High / Low Blood Pressure
☐ Fever Blisters
☐ Severe / Frequent Headaches
☐ Blood Transfusion
☐ Hospitalized for any reason
☐ Psychiatric Problems
☐ Epilepsy / Seizures
☐ Fainting Spells
☐ Diabetes / Tuberculosis
☐ Drug / Alcohol Abuse
☐ Venereal Disease
☐ Hemophilia / Abnormal Bleeding
☐ Kidney Problems
☐ Ulcers / Colitis
☐ Radiation Treatment
☐ Arthritis
☐ Asthma
☐ Hepatitis

Any medical conditions that you have that we need to know about? ____
____

Are you allergic to any of the following drugs?

☐ Penicillin ☐ Aspirin ☐ Erythromycin ☐ Tetracycline
☐ Codeine ☐ Latex ☐ Dental Anesthetics ☐ Other ________________________

DENTAL HISTORY (Please check all that apply)

☐ Have you ever had a bad dental experience or are you nervous when you are visiting the dentist?
☐ Have you ever been instructed in caring for your teeth and gums?
☐ Do your gums ever bleed or feel sore?
☐ Do any of your teeth feel loose?
☐ Are any of your teeth sensitive to hot or cold foods or drinks?
☐ Are you happy with the color of your teeth?
☐ Do you like the shape and size of your teeth?
What would you like to change the most in the appearance of your teeth? _____________________________
____

I understand that the information that I have given today is correct to the best of my knowledge. I authorize Stockbridge Dental Care, P.C. to perform any treatment deemed necessary. I understand that this information will be held in the strictest confidence and it is my responsibility to inform Stockbridge Dental Care, P.C. of any changes in my medical history.

Patient (or Guardian) Signature ________________________________ Date: ______________

Doctor's Notes ____

Medical History reviewed: Date / Dr. Date / Dr. Date / Dr.