Capener & Matthews Dental

MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Physician's Name:_____

1. Are you now or have you been under a physician's care within the past year?…… YES NO

   If Yes, specify condition being treated _____
2. Do you take any medications, including birth control pills, or herbal supplements?…….. YES NO
   Please specify name and purpose of medications: _____
   _____
3. Do you have or have you ever had any heart or blood problems?…….YES NO
4. Do you require antibiotic pre-medication for an artificial valve or artificial joint? . . . . . .YES NO
5. Do you have or have you ever had high blood pressure? . . . . . YES NO
6. Do you bleed or bruise easily? . . . .YES NO
7. Have you ever been diagnosed with a sexually transmitted disease? . . . . ……YES NO
8. Have you ever had hepatitis or liver disease? . . . . . .YES NO

9. Have you ever had:

Rheumatic Fever…	YES	NO	Heart Attack…..	YES	NO	Diabetes……	YES	NO
Asthma…….	YES	NO	Seizures……	YES	NO	Cancer or Tumor/growth…	YES	NO
Kidney Disease....	YES	NO	Tuberculosis…..	YES	NO	Immune System Disorder…	YES	NO
Arthritis……. .	YES	NO	Blood Disorder..	YES	NO			

   Other _____?

10. Have you ever had an unusual reaction or are you allergic to any of the following:

Penicillin……..…	YES	NO	Latex……..	YES	NO	Non-precious metals……	YES	NO
Aspirin…..……	YES	NO	Acetaminophen..	YES	NO	Ibuprofen…….	YES	NO
Codeine……	YES	NO	Sulfa Drugs……..	YES	NO			

11. Do you have any other allergies? If Yes, please describe:_____
12. Are you subject to fainting? . . . . . .YES NO
13. Have you ever used tobacco or tobacco products?……..... YES NO
14. When was your last dental visit?_____
15. Who was your previous dentist? _____
16. Have you ever had a severe reaction to dental treatment or local anesthetic?…….. YES NO
17. Are you having or have you had problems with your TMJ (jaw joint)?……YES NO
18. Do you have or have you ever had bleeding or sensitive gums?……... YES NO
19. Would you like any information on fresh breath?……. YES NO
20. If you could change anything about your smile, what would it be?……. YES NO
21. Women: Are you pregnant? . . . . . …… YES NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE PRECEDING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ Date_____
(Patient, legal guardian or authorized agent of patient)

For completion by the dentist or dental staff.

Findings:_____

_____

_____

_____

_____
Date Signature of Dentist of Staff Member

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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