DALLAS DENTAL GROUP

COMPREHENSIVE RESTORATIVE, COSMETIC, AND FAMILY DENTISTRY

MEDICAL & DENTAL HISTORY FORM

Patient Name*: ____________ ____________ ____ ____________

Last | First | Mi | Preferred Name

Within the past year, have there been any changes in your general health? * ◯ Yes ◯ No

If Yes, please explain: ____________

What is the date of your last medical exam? * ____________

Please list your Primary Care Physician's name, address, & phone number: * ____________

Have you been hospitalized within the last 5 years due to a surgery or illness? * ◯ Yes ◯ No

If Yes, please explain: ____________

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? * ◯ Yes ◯ No Date: ____________

Does your physician recommend that you take antibiotics prior to dental treatment? * ◯ Yes ◯ No ◯ I don't know

Are you taking or scheduled to begin taking either of the medications, Fosamax or Actonel for osteoporosis or Paget's disease?

* ◯ Yes ◯ No

PLEASE LIST ALL MEDICATIONS: (prescription and non-prescription) ____________

Please list pharmacy name and phone #: ____________

Have you ever had any complications following dental treatment? * ◯ Yes ◯ No

If Yes, please explain: ____________

Do you use tobacco (smoking or chewing)? * ◯ Yes ◯ No WOMAN ONLY: Are you pregnant? * ◯ Yes ◯ No

If Yes, when is the due date? ____________

Please check any of the following that apply to you:

◯ * Pre - Med - Amox	◯ * Pre - Med - Clind	◯ * Pre - Med - Other	◯ Allergies	◯ Allergy - Aspirin
◯ Allergy - Codeine	◯ Allergy - Erythro	◯ Allergy - Hay Fever	◯ Allergy - Latex	◯ Allergy - Other
◯ Allergy - Penicillin	◯ Allergy - Sulfa	◯ Anemia	◯ Anesthetic – no vaso	◯ Arthritis
◯ Artificial Joints	◯ Asthma	◯ Back Problems	◯ Blood Disease	◯ Cancer
◯ Crohn's	◯ Diabetes	◯ Dizziness	◯ Epilepsy	◯ Excesive Bleeding
◯ Fainting	◯ Glaucoma	◯ Head Injuries	◯ Headaches	◯ Heart Disease
◯ Heart Murmur	◯ Hepatitis	◯ High Blood Pressure	◯ HIV	◯ Jaundice
◯ Kidney Disease	◯ Liver Disease	◯ Lupus	◯ Mental Disorders	◯ MVP
◯ Nervous Disorders	◯ Other	◯ Pacemaker	◯ Pregnancy	◯ Radiation Treatment
◯ Respiratory Problems	◯ Rheumatic Fever	◯ Rheumatism	◯ Shingles	◯ Sinus Problems
◯ Stomach Problems	◯ Stroke	◯ Thyroid Problems	◯ Tuberculosis	◯ Tumors
◯ Ulcers	◯ Venereal Disease			

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Are you in any discomfort now? * ○ Yes ○ No

Please check any of the following problems that apply:

○ Discomfort, clicking or popping in jaw
○ Sensitive tooth, teeth or gums
○ Lost/Broken Filling(s)
○ Ringing in ears
○ Stained teeth
○ Bad Breath
○ Red, swollen or bleeding gums
○ Blisters/Sores in or around the mouth
○ Teeth grinding/clenching
○ Broken/Chipped Tooth
○ Locking Jaw
○ Other

When was your last dental visit? * ______________________

Prior Dentist's name, address, & phone number: ______________________

How frequently do you brush your teeth?

* ○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

* ○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

If you could change anything about your mouth, teeth, or smile, what would it be? ______________________

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* ○ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

* ○ I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

Response Date: ______________________