CARTER AND HOFF DENTISTRY

Today's Date_____ **Patient Name**_____ **DOB**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you.

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DENTAL HISTORY:

What is the reason for today's visit?_____

Date of last dental visit_____ Last cleaning_____ Last dental x-rays_____

Do you have any dental problems now? Y / N If yes, please describe:_____

Are you satisfied with your teeth's appearance? Y / N If no, please describe:_____

Have you ever been treated for periodontal disease (gum disease) ? Y / N Do your gums hurt or bleed easily? Y / N

Do you smoke tobacco? Y / N Do you chew tobacco? Y / N Do you feel nervous about having dental treatment? Y / N

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MEDICAL HISTORY:

Are you under a physician's care now? Y / N Name of Physician_____

Have you ever been hospitalized or had a major operation? Y / N If yes, please describe:_____

Have you ever had a serious head or neck injury? Y / N If yes, please describe:_____

Do you use controlled substances? Y / N Have you ever taken Phen-Fen or Redux? Y / N

Are you on a special diet? Y / N If yes, please describe:_____

Have you ever taken any prescription medication for osteoporosis or osteopenia? Y / N If yes, have you taken any of the following:

Y / N Fosamax(Alendronate) Y / N Actonel(Residronate) Y / N Aredia(Pamidronate)

Y / N Boniva(Ibandronate) Y / N Reclast(Zoledronate) Y / N Zometa(Zoledronate)

Please list any medications, pills, or drugs you are currently taking:_____

_____

Are you allergic to any of the following?

Y / N	Aspirin	Y / N	Erythromycin	Y / N	Latex		
Y / N	Tetracycline	Y / N	Acrylic	Y / N	Penicillin	Y / N	Metal
Y / N	Dental Anesthetics	Y / N	Codeine	Y / N	Sulfa Drugs	Y / N	Other_____

Women: Are you pregnant or trying to get pregnant? Y / N Are you currently nursing? Y / N

Are you currently using prescription contraceptives? Y / N If yes, please describe:_____

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Do you currently have or have you ever had any of the following? (Please circle yes or no for each condition.)

Y / N AIDS/HIV	Y / N Convulsions	Y / N Heart Pace Maker	Y / N Psychiatric Care
Y / N Alzheimer's Disease	Y / N Cortisone Medicine	Y / N Heart Trouble/Disease	Y / N Radiation Treatments
Y / N Anaphylaxis	Y / N Diabetes	Y / N Hemophilia	Y / N Recent Weight Loss
Y / N Anemia	Y / N Drug Addiction	Y / N Hepatitus A	Y / N Renal Dialysis
Y / N Angina	Y / N Easily Winded	Y / N Hepatitus B or C	Y / N Rheumatic Fever
Y / N Arthritis or Gout	Y / N Emphysema	Y / N Herpes	Y / N Rheumatism
Y / N Artificial Heart Valve	Y / N Epilepsy or Seizures	Y / N High Blood Pressure	Y / N Scarlet Fever
Y / N Artificial Joint	Y / N Excessive Bleeding	Y / N Hives or Rash	Y / N Shingles
Y / N Asthma	Y / N Excessive Thirst	Y / N Hypoglycemia	Y / N Sickle Cell Disease
Y / N Blood Disease	Y / N Fainting or Dizziness	Y / N Irregular Heartbeat	Y / N Sinus Trouble
Y / N Blood Transfusion	Y / N Frequent Cough	Y / N Kidney Problems	Y / N Spina Bifida
Y / N Breathing Problem	Y / N Frequent Diarrhea	Y / N Leukemia	Y / N Stomach/GI Disease
Y / N Bruise Easily	Y / N Frequent Headaches	Y / N Liver Disease	Y / N Stroke
Y / N Cancer	Y / N Genital Herpes	Y / N Low Blood Pressure	Y / N Swelling of Limbs
Y / N Chemotherapy	Y / N Glaucoma	Y / N Lung Disease	Y / N Thyroid Disease
Y / N Chest Pains	Y / N Hay Fever	Y / N Mitral Valve Prolapse	Y / N Tonsillitis
Y / N Cold Sores/Fever Blisters	Y / N Heart Attack/Failure	Y / N Pain in Jaw Joints	Y / N Tuberculosis
Y / N Congenital Heart Disorder	Y / N Heart Murmur	Y / N Parathyroid Disease	Y / N Tumors or Growths
Y / N Ulcers	Y / N Venereal Disease	Y / N Yellow Jaundice	Y / N Eating Disorder
Y / N Mental Heath Disorder	Other_____		

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Parent or Guardian (if minor) _____ **Date**_____

Signature of Treating Dentist _____ **Date**_____

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For Dental Staff Only: Please date and initial at each health update. **Please place medical alert stickers here.**

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