WEST ASHLEY
FAMILY DENTISTRY

Patient Medical and Dental History Form

Please take a few minutes to carefully read over and answer the following questions to help us treat you safely.
If you have any questions, we will be glad to assist you.

Patient Name:_____ Birth date:_____ Today's Date:_____

Dental History

Reason for today's visit:_____
Former Dentist:_____ City:_____ State:_____
Date of last dental visit:_____ Date of last dental X-rays:_____

Please place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	□Yes	□No	Grinding teeth	□Yes	□No	Loose or broken fillings	□Yes	□No
Dry mouth	□Yes	□No	Clicking or popping of jaw	□Yes	□No	Food stuck between the teeth	□Yes	□No
Mouth Breathing	□Yes	□No	Jaw pain or tiredness	□Yes	□No	Lip or cheek biting	□Yes	□No
Bleeding gums	□Yes	□No	Blisters on mouth	□Yes	□No	Fingernail biting	□Yes	□No
Gums swollen or tender	□Yes	□No	Burning sensation on tongue	□Yes	□No	History of tobacco use	□Yes	□No

Is there anything that you would like to change about your teeth? _____

Medical History

Physician's Name:_____ Date of last visit:_____

AIDS/HIV	□Yes	□No	Emphysema	□Yes	□No	Radiation Treatment	□Yes	□No
Anemia	□Yes	□No	Epilepsy	□Yes	□No	Respiratory Disease	□Yes	□No
Arthritis, Rheumatism	□Yes	□No	Fainting or Dizziness	□Yes	□No	Shortness of Breath	□Yes	□No
Artificial Heart Valves	□Yes	□No	Glaucoma	□Yes	□No	Sinus Trouble	□Yes	□No
Artificial Joints	□Yes	□No	Headaches	□Yes	□No	Skin Rash	□Yes	□No
Asthma	□Yes	□No	Heart Problems	□Yes	□No	Special Diet	□Yes	□No
Bacterial Endocarditis	□Yes	□No	-What type?_____			Stroke	□Yes	□No
Bleeding Abnormally			Hepatitis, type _____	□Yes	□No	Swollen Feet or Ankles	□Yes	□No
with extractions or surgery	□Yes	□No	Herpes	□Yes	□No	Swollen Neck Glands	□Yes	□No
Blood Disease	□Yes	□No	High Blood Pressure	□Yes	□No	Thyroid Problems	□Yes	□No
Cancer	□Yes	□No	Jaundice	□Yes	□No	Tonsillitis	□Yes	□No
Chemical Dependency	□Yes	□No	Kidney Disease	□Yes	□No	Tuberculosis	□Yes	□No
Chemotherapy	□Yes	□No	Liver Disease	□Yes	□No	Tumor or growth on head		
Circulatory Problems	□Yes	□No	Low Blood Pressure	□Yes	□No	or neck	□Yes	□No
Congenital Heart Lesions	□Yes	□No	Nervous System Problems	□Yes	□No	Ulcer	□Yes	□No
Cortisone Treatments	□Yes	□No	Pacemaker	□Yes	□No	Venereal Disease	□Yes	□No
Cough, persistent or bloody	□Yes	□No	Psychiatric Care	□Yes	□No	Weight Loss, unexplained	□Yes	□No
Diabetes	□Yes	□No						

Do you have an allergy to □No Known Allergies □Aspirin □Barbiturates (sleeping pills) □Codeine □Iodine □Latex
□Local Anesthetic □Penicillin □Sulfa □Other:_____

Do you wear contact lenses? □Yes □No

Women:
Are you pregnant? □Yes □No Due date:_____ Are you nursing? □Yes □No
Taking Birth Control Pills? □Yes □No

Please list any medications you are currently taking and what you are taking it for:_____
_____

Pharmacy Name:_____ Phone:_____