HAWS FAMILY DENTISTRY

MEDICAL HISTORY

Patient's Name _____ Date of Birth _____
(Please print name)

Medical Doctor _____ Doctor's Phone: _____
(First and last name, please)

1. Have you been a patient in a hospital during the past year? . . . . . YES NO
2. Have you been under the care of a physician during the past year? . . . . . YES NO
3. Date of last medical exam: _____
4. Are you taking any of the following drugs: (Circle and explain.)

Antibiotics	Steroids	High Blood Pressure meds
Tranquilizers	Anticoagulants (blood thinners)	Insulin or similar
Heart Medications	Aspirin	Hormones

Others: _____

5. Are you allergic to any medicine or drugs? If so, please list: _____
6. Have you ever had excessive/prolonged bleeding requiring special treatment? . . . . . YES NO
7. Have you had any adverse reaction to local anesthetics? . . . . . YES NO
8. WOMEN ONLY! Are you pregnant? If YES, how many months? _____ . . . . . YES NO
9. CIRCLE any of the following which you have at present or have had:

Hepatitis	Pacemaker	Heart Attack	Thyroid Disease	Liver Disease
Heart Surgery	Coronary Artery Disease	Cortisone Treatment	Jaundice (other than infant)	
Artificial Joint	Arteriosclerosis	Allergies	AIDS/HIV+	X-Ray Therapy
Hardening of Arteries	Latex Allergy	Tuberculosis	Cobalt Therapy	High Blood Pressure
Asthma	Rheumatic Fever	Leukemia	Heart Failure	Arthritis
Heart Defect	Hemophilia	Stroke	Rheumatism	Artificial Heart Valve
Anemia	Diabetes	Epilepsy	Heart Murmur	Heart Disease
Kidney Trouble/Disease	Seizures/Dizzy Spells	Any disease/condition/problem not listed: _____		

10. Do you require antibiotic premedication for a heart condition, artificial valve or artificial joint? . . . . . YES NO
11. Have you ever had an unusual reaction or are you allergic to any of the following drugs? . . . . . YES NO

Penicillin _____; Aspirin _____; Acetaminophen _____; Ibuprofen _____; Codeine _____; Barbiturates _____; Sulfa Drugs _____;
Other _____

12. Are you subject to fainting? . . . . . YES NO
13. Do you have any allergies? If so, please describe: _____ YES NO
14. Have you ever had a nervous breakdown or undergone psychiatric treatment? . . . . . YES NO
15. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? . . . . . YES NO
16. Are you having dental pain or discomfort at this time? . . . . . YES NO
17. Do you feel very nervous about having dental treatment? . . . . . YES NO
18. Do you use tobacco? If YES, what type and how much per day? . . . . . YES NO
19. When did you last have dental work? _____ Did they take x-rays? . . . . . YES NO
20. Teeth cleaned? _____
21. What type of toothbrush do you use? (soft, medium, hard, electric) _____
22. How often do you brush? _____ Floss? _____
23. Who was your previous dentist? _____
24. Do you think that your teeth are affecting your general health in any way? . . . . . YES NO
25. Do you have or have you ever had bleeding or sensitive gums? . . . . . YES NO

The above information is true and correct to the best of my knowledge.

ADULT (18 years and older)

_____
Patient's Signature

_____
Date

MINOR (and other dependents)

_____
Signature of minor patient's parent/guardian

_____
Relationship to patient/Authority to give consent