Royal Oak Family Dentistry

MEDICAL HISTORY

How is your general health? O Excellent O Good O Fair O Poor
Are you under a physician's care now? O Yes O No — If yes, please explain: _____
Primary care physicians' name and phone number: _____
Been hospitalized or had a major operation in the last 3 years? O Yes O No — If yes, please explain: _____
Have you ever had a serious head or neck injury? O Yes O No — If yes, please list all medications: _____
Are you taking any medications, pills, or drugs? O Yes O No _____
Are you on a special diet? O Yes O No _____
Do you use tobacco? O Yes O No _____
Do you use controlled substances? O Yes O No
Are you currently seeing a specialist? O Yes O No — Name and Number: _____

Women:
Are you pregnant/trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Dental Health:

Are you afraid of seeing a dentist? O Yes O No
Do your gums bleed while brushing or flossing? O Yes O No
Do you avoid brushing any areas do to pain/sensitivity? O Yes O No
Do your gums feel tender or swollen? O Yes O No
Do you clench or grind your teeth while sleeping or while awake? O Yes O No
Do you have problems eating? O Yes O No
Do you have bad breath? O Yes O No
Have you ever responded unfavorably to medical or dental care? O Yes O No

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Tylenol O Latex O Local Anesthetics
O Other (food allergies, ect.): Please list: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Easily Winded	O Yes O No	Leukemia	O Yes O No
Anaphylaxis	O Yes O No	Emphysema	O Yes O No	Liver Disease	O Yes O No
Anemia	O Yes O No	Epilepsy or Seizures	O Yes O No	Lung Disease	O Yes O No
Angina	O Yes O No	Excessive Bleeding	O Yes O No	Nutritional Deficiency	O Yes O No
Arthritis/Gout	O Yes O No	Excessive Thirst	O Yes O No	Pain in Jaw Joints	O Yes O No
Artificial Heart Valve	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Psychiatric Care	O Yes O No
Artificial Joint	O Yes O No	Frequent Cough	O Yes O No	Radiation Treatment	O Yes O No
Asthma	O Yes O No	Frequent Diarrhea	O Yes O No	Recent Weight Loss	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Renal Dialysis	O Yes O No
Bruise Easily	O Yes O No	Glaucoma	O Yes O No	Rheumatism	O Yes O No
Cancer	O Yes O No	Hay Fever	O Yes O No	Sickle Cell Disease	O Yes O No
Chemotherapy	O Yes O No	Heart Pace Maker	O Yes O No	Sinus Trouble	O Yes O No
Chest Pain	O Yes O No	Heart Trouble/Disease	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Hemophilia	O Yes O No	Stroke	O Yes O No
Congenital Heart Disorder	O Yes O No	Hepatitis A	O Yes O No	Swelling of Limbs	O Yes O No
Convulsions	O Yes O No	Hepatitis B or C	O Yes O No	Thyroid Disease	O Yes O No
Cortisone Medicine	O Yes O No	O High/ O /Low Blood Pressure	O No	Tuberculosis	O Yes O No
Diabetes	O Yes O No	Hives or Rash	O Yes O No	Tumors or Growths	O Yes O No
Drug Addiction	O Yes O No	Hypoglycemia	O Yes O No	Ulcers	O Yes O No

AUTHORIZATIONS:
The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes.

Signature of patient, parent or guardian: _____ Date:_____

Doctor Notes:
_____
_____
_____
_____
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