alliance dentistry™

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Please list other medications you are taking:
_____
_____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Psychiatric Treatment	Yes No	Hepatitis B	Yes No	Tobacco Products	Yes No

Sickle Cell Disease	Yes No	Hepatits C or D	Yes No	Bruise Easily	Yes No
Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No	Radiation Therapy	Yes No	Transplant	Yes No

Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name / location:_____
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes No	Sensitivity to:	Hot	Cold	Sweets	Biting
Pain in or around your ears	Yes No	Swelling		Bleeding Gums		
Difficulty opening or closing	Yes No	Bad Taste		Bad Breath		
Difficulty chewing	Yes No	Food Catching		Tooth Pain		
History of trauma to jaw or face	Yes No	Clenching		Grinding		
Diagnosis of TMJ/TMD	Yes No	Other: _____				

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date_____

Doctor's Signature_____

Doctor's Notes: