

NORTHWOODS DENTAL MEDICAL HISTORY

Today's date _____

Patient Name _____

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

Are you under a physician's care now? Yes No Name of Physician: _____

Last visit: _____

Have you been hospitalized or had a major operation? Yes No Type _____ Date(s) _____

Have you ever had a serious head or neck injury? Yes No Describe _____

Do you or have you used Tobacco (Cigarettes/Chewing Tobacco /Cigars)? Yes No
Amount per day _____ For how many years _____

Do you use controlled substances? Yes No Do you chronically snore? Yes No

Are you taking any weight loss pills containing ephedra? Yes No

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa
 Other _____ Reaction: _____

List any medications you are currently taking: _____

Do you take a daily aspirin? Yes No

Do you need to be pre-medicated with an antibiotic prior to dental treatment? _____

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

<input type="checkbox"/> Any heart problems	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Smoker	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Malignancies	<input type="checkbox"/> Asthma	<input type="checkbox"/> AIDS - HIV
<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental health care
<input type="checkbox"/> Prosthetic implant	<input type="checkbox"/> Anemia	<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Anorexia/Bulimia

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, GUARDIAN

SIGNATURE OF TREATING DOCTOR

Please turn over and complete other side