Humlicek Family Dental

Patient Medical History

Patient Name: Date of Birth: Today's Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health issues 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 so we can best serve you.

Please answer the following questions

	Yes	No	
Do you currently see a general doctor? If yes, please provide name and phone number.	◯	◯	If yes, _____
Have you ever been hospitalized or had a major operation? If yes, please provide year and operation.	◯	◯	If yes, _____
Have you ever had a serious head or neck injury? If yes, please provide year and injury.	◯	◯	If yes, _____
Do you take, or have you taken, Phen-Fen or Redux?	◯	◯	If yes, _____
Have you ever taken an osteoporosis medication such as Fosamax, Boniva, Actonel, or any other medication containing biophosphonates?	◯	◯	If yes, _____
Do you smoke or chew tobacco? Please specify which. How often and how long?	◯	◯	If yes, _____
Do you take hydrocodone or other controlled substances?	◯	◯	If yes, _____
Do you take a blood thinner?	◯	◯	If yes, _____
Have you done, or do you take, recreational drugs?	◯	◯	If yes, _____
Are you taking any medications, pills, or drugs that have not been mentioned?	◯	◯	If yes, _____

For 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 ◯ Sulfa Drugs ◯ Local Anesthetics

Other? ◯ If yes, _____

Please proceed to the next page.

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

AIDS/HIV Positive ◯	Cortisone Medicine ◯	Hemophilia ◯	Radiation Treatments ◯
Alzheimer's Disease ◯	Diabetes Type 1 ◯	Hepatitis A ◯	Anaphylaxis ◯
Drug Addiction ◯	Diabetes Type 2 ◯	Hepatitis B or C ◯	Anemia ◯
Easily Winded ◯	Rheumatic Fever ◯	Angina ◯	Emphysema ◯
High Blood Pressure ◯	Rheumatism ◯	Arthritis/Gout ◯	Epilepsy Seizures ◯
High Cholesterol ◯	Scarlet Fever ◯	Artificial Heart Valve ◯	Excessive Bleeding ◯
Hives or Rash ◯	Shingles ◯	Artificial Joint ◯	Excessive Thirst ◯
Hypoglycemia ◯	Sickle Cell Disease ◯	Asthma ◯	Fainting/Dizziness ◯
Irregular Heartbeat ◯	Sinus Trouble ◯	Blood Disease ◯	Frequent Cough ◯
Kidney Issues ◯	Renal Dialysis ◯	Blood Transfusion ◯	Leukemia ◯
GERD ◯	Breathing Problems ◯	Frequent Headaches ◯	Liver Disease ◯
Stroke ◯	Bruise Easily ◯	Low Blood Pressure ◯	Swelling of Limbs ◯
Cancer ◯	Glaucoma ◯	Lung Disease ◯	Thyroid Disease ◯
Chemotherapy ◯	Mitral Valve Prolapse ◯	Tonsillitis ◯	Chest Pains ◯
Heart/Attack Failure ◯	Osteoporosis ◯	Tuberculosis ◯	Cold Sores/Fever Blisters ◯
Parathyroid Disease ◯	Ulcers ◯	Convulsions ◯	Heart Trouble/Disease ◯
Depression/Anxiety ◯	Sexually Transmitted Disease (STD) ◯		

Have you had any serious illness(es) not listed above? Yes ◯ No ◯ If yes, _____

Dental History

	Yes	No	
When was your last visit to the dentist?	◯	◯	If yes, _____
Have you had dental x-rays taken in the last year?	◯	◯	If yes, _____
Are you experiencing dental pain?	◯	◯	If yes, _____
Do you have any jaw pain/popping/clicking?	◯	◯	If yes, _____
Do you snore at night?	◯	◯	If yes, _____
Do you grind your teeth at night, or under stress?	◯	◯	If yes, _____
Have you ever been numb for a dental cleaning?	◯	◯	If yes, _____
Is there anything you would like to change about your smile?	◯	◯	If yes, _____

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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X _____ Date: _____