Medical History

What is the reason for your visit today?

____

Date of last dental visit ________________ **Last Dental Cleaning** _______________ **Last Full Mouth X-rays** _____________________

What was done at your last dental visit? ____

Previous Dentist's Name: ____
Address: ____State: _______________ Zip: ____________
Telephone: ____

1. Have you been under the care of a medical doctor in the past 2 years? Yes____ No ____
   If yes, for what? ____
   Physician's Name: ________________________________ Phone: ____
   Address: ____ City: ____________________State: _______ Zip:________________
2. Have you taken any medication or drugs during the past 2 years? Yes____ No ____
3. Are you taking any medication, drugs or pills now? Yes____ No ____
   If yes, please list name and dosage: ____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes ____ No ____
   If yes, please list: ____
5. Have you been a patient in the hospital during the past five years? Yes ____ No ____
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Venereal Disease	Yes No
Chest Pain	Yes No	Diabetes	Yes No	A.I.D.S.	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	H.I.V. Positive	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	Cold Sores/Fever Blisters	Yes No
High Blood Pressure	Yes No	Contact lenses	Yes No	Blood Transfusion	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Hemophilia	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Sickle Cell Disease	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Bruise Easily	Yes No
		Asthma	Yes No	Liver Disease	Yes No
Rheumatic Fever	Yes No	Hay Fever	Yes No	Yellow Jaundice	Yes No
Arthritis/Rheumatism	Yes No	Latex Sensitivity	Yes No	Neurological Disorders	Yes No
Cortisone Medicine	Yes No	Allergies or Hives	Yes No	Epilepsy or Seizures	Yes No
Swollen Ankles	Yes No	Sinus Trouble	Yes No	Fainting or Dizzy Spells	Yes No
Stroke	Yes No	Radiation Therapy	Yes No	Nervous/Anxious	Yes No
Diet (Special/Restricted)	Yes No	Chemotherapy	Yes No	Psychiatric/Psychological Care	Yes No
Kidney Trouble	Yes No	Tumors	Yes No		
		Hepatitis A (infectious) B (serum)	Yes No		

7. Do you use more than two pillows to sleep? Yes No
8. Have you lost or gained more than 10 pounds in the past year? Yes No
9. Do you have or have you had any disease, condition, or problem not listed? Yes No
   If yes, please list: ____
10. **Women**. Are you: **Pregnant?** Yes _____months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature:____ Date: ______________________

Provider Signature: ____ Date: ______________________

CAMINO HEALTH CENTER

REASON FOR VISIT AND DENTAL HEALTH HISTORY

CONFIDENTIAL

Patient Name ____ Date of Birth ______________________

For today's Dental visit, please check ALL boxes that apply:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking, popping or locked jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth, broken fillings or crown work
- ☐ Periodontal (gum) treatment
- ☐ Sensitivity to cold, hot, sweet, air (please circle)
- ☐ Sensitivity when biting/chewing
- ☐ Sores, blisters or growth in your mouth
- ☐ Denture problem/question
- ☐ Implant/bridge problems/questions

Do you or your child brush? ☐ Yes ☐ No

Do you or your child floss? ☐ Yes ☐ No

MEDICAL HISTORY UPDATE

Last Medical visit with physician: _____________________________ Physician's name: _______________________

Has your or your child's health changed in the last 6 months? ☐ Yes ☐ No If Yes, explain __________________________

Are you or your child currently taking medication? ☐ Yes ☐ No If Yes, list ____________________________________

Have you or your child had any serious illness or operations in the last 6 months? ☐ Yes ☐ No If Yes, explain ____________

Have you or your child ever had a blood transfusion? ☐ Yes ☐ No

(Adults Only) Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Iomin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ☐ Yes ☐ No

(Adults Only) Are you taking or scheduled to begin taking either of the following medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No If Yes, how many months _________

Breast feeding? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

ALLERGIES

Do you or your child have any of the following allergies?

- ☐ Latex
- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _________________________________

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _______________ Patient/Parent/Guardian Signature_____________________________________

Date ________________Provider Signature____________________________________