Medical History

1. Are you having any dental problems at this time?..... ☐yes ☐no

If so, please describe:

2. Do your gums bleed at any time? ..... ☐yes ☐no
3. Do you feel nervous about dental service or treatment?..... ☐yes ☐no
4. Have you ever had a bad experience at the dental office?..... ☐yes ☐no

4a. Please rate your level of anxiety concerning dental treatment ☐none at all ☐somewhat anxious ☐very anxious ☐terrified

4b. Do you ever have your teeth "filled" without anesthesia (novocaine)?..... ☐yes ☐no

5. Have you been a patient in the hospital during the past two years?..... ☐yes ☐no

If so, for what reason?

6. Have you been under the care of a medical doctor during the past two years?..... ☐yes ☐no

If yes, for what reason?

7. Have you taken any medicine or drugs during the past two years?..... ☐yes ☐no

If yes, please list:

8. Are you allergic to (i.e. itching, rash, hives, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?..... ☐yes ☐no

If yes, please list:

9. Are you allergic to anything else? If so, please list:
10. Have you ever had excessive bleeding requiring special treatment?..... ☐yes ☐no

11. Check any of the following that you have had or have at the present time:

☐ **Heart Failure**	☐ **Stroke**	☐ **Radiation or Cobalt Treatment**	☐ **Blood Transfusion**
☐ **Heart Disease or Attack**	☐ **Kidney Trouble**	☐ **Chemotherapy (Cancer or Leukemia)**	☐ **Drug Addiction**
☐ **Angina Pectoris (chest pain)**	☐ **Ulcers**	☐ **Arthritis**	☐ **Hemophilia**
☐ **High Blood Pressure**	☐ **Shortness of Breath**	☐ **Venereal Disease (Syphilis or Gonorrhea)**	☐ **Rheumatism**
☐ **Heart Murmur**	☐ **Emphysema**	☐ **Cold Sores or Fever Blisters**	☐ **Cortisone Medication**
☐ **Rheumatic Fever**	☐ **Cough**	☐ **Glaucoma**	☐ **Genital Herpes**
☐ **Congenital Heart Lesions**	☐ **Tuberculosis (TB)**	☐ **Pain in Jaw Joints**	☐ **Epilepsy or Seizures**
☐ **Artificial Heart Valve**	☐ **Asthma**	☐ **Cosmetic Surgery**	☐ **Fainting or Dizzy Spells**
☐ **Artificial Joint**	☐ **Hay Fever**	☐ **HIV Positive (AIDS)**	☐ **Nervousness**
☐ **Heart Pacemaker**	☐ **Sinus Trouble**	☐ **Hepatitis A (infectious)**	☐ **Psychiatric Treatment**
☐ **Heart Surgery**	☐ **Sensitivity to Metals**	☐ **Hepatitis B (Serum)**	☐ **Sickle Cell Anemia**
☐ **Latex Allery/Sensitivity**	☐ **Diabetes**	☐ **Liver Disease**	☐ **Bruise Easily**
☐ **Anemia**	☐ **Thyroid Disease**	☐ **Liver Jaundice**	

12. Are you pregnant at this time?..... ☐yes ☐no

If so, please indicate what month you are due:

Are you taking birth control pills? ..... ☐yes ☐no

13. Do you use or have you ever used recreational drugs? ..... ☐yes ☐no
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?..... ☐yes ☐no
15. Do your ankles swell during the day? ..... ☐yes ☐no
16. Have you lost or gained more than 10 lbs. in the past year? ..... ☐yes ☐no
17. Do you have to use more than two pillows to sleep in a propped up position? ..... ☐yes ☐no
18. Do you ever wake up from sleep short of breath? ..... ☐yes ☐no
19. Are you on a special diet? ..... ☐yes ☐no
20. Has your physician ever said you have cancer or a tumor? ..... ☐yes ☐no
21. Do you have any disease, condition, or problem not listed on this medical history form? ..... ☐yes ☐no
22. List all medication that you are taking at this time:
23. List any current medical problems you have been treated for in the past:
24. Do you smoke?..... ☐yes ☐no

What do you smoke: ☐Cigar ☐pipe ☐cigarettes How much per day do you smoke:

25. Do you use oral tobacco products? ☐yes ☐no If so, for how long?

I hereby authorize the Doctors of Modern Dental Associates to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient below and further authorize and consent that the doctor of Modern Dental Associates chooses and employs such assistance as he decrees fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor. I agree to pay for all services rendered by Modern Dental Associates. I understand that all patient information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status and/or insurance coverage. I have read, understand, and agree to the policies of this office.

SIGNATURE OF PATIENT/GUARDIAN: **DATE:**