PATIENT MEDICAL HISTORY

PATIENT NAME _____ **Birth Date:** _____/_____/_____

Are you under a physician's care now? [ ] Yes [ ] No *If yes, please explain*:

_____

Have you ever been hospitalized or had a major operation? [ ] Yes [ ] No *If yes, please explain*:

_____

Have you ever had a serious head or neck injury? [ ] Yes [ ] No *If yes, please explain*:

_____

Are you taking any medications, pills, or drugs? [ ] Yes [ ] No *If yes, please explain*:

_____

Are you on a special diet? [ ] Yes [ ] No *If yes, please explain*:

_____

Do you use chew tobacco, smoke, or vape? [ ] Yes [ ] No
Do you use recreational drugs? [ ] Yes [ ] No
Do you use controlled substances? [ ] Yes [ ] No *If yes, please explain*:

_____

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

[ ] Artificial joint or valve
[ ] AIDS or HIV positive
[ ] Anemia or blood disorders
[ ] Neurologic condition
[ ] Hepatitis: **A B C** **Circle One**
[ ] Alcoholism
[ ] Diabetes: **Type 1** or **Type 2** **Circle One**
[ ] Arthritis
[ ] Hay fever or sinus trouble
[ ] Kidney disease
[ ] Heart ailment or angina
[ ] Pacemaker
[ ] Allergies or Hives
[ ] Penicillin Allergy
[ ] Acrylic Allergy
[ ] Latex Allergy
[ ] Blood Pressure: **High** or **Low** **Circle One**
[ ] Migraine headaches or frequent headaches
[ ] Abnormal bleeding after extractions, surgery, or trauma
[ ] Epilepsy, seizures, or fainting spells
[ ] Cancer or tumor _____
[ ] Blood transfusion
[ ] Emotional condition
[ ] Herpes or cold sores
[ ] Asthma
[ ] Heart murmur, mitral valve prolapses, heart defect
[ ] Rheumatic fever or rheumatic heart disease
[ ] Tuberculosis or other lung problems
[ ] Aspirin Allergy
[ ] Codeine Allergy
[ ] Metal Allergy
[ ] Allergy to Local Anesthetics

Have you ever had any serious illness not listed above? [ ] Yes [ ] No *If yes, please explain*:

_____

***WOMEN ONLY*:**

Are you Pregnant/Trying to get pregnant? **[ ] Yes [ ] No**
Taking oral contraceptives? **[ ] Yes [ ] No**
Issues with menstruation? **[ ] Yes [ ] No**
Nursing Mother? **[ ] Yes [ ] No**

_____

To the best of my knowledge, I have truthfully given Brush Dental my medical history. I understand the above information is necessary to provide me with dental care in a safe and efficient manner.

X_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN **DATE**