Springbrook
FAMILY DENTISTRY

# Medical History

Last Name: _____ First Name: _____ Date of Birth: _____

Name of Medical Doctor: _____ City/State: _____

Have you been hospitalized in the past 5 years: _____

## Medical History

List of all medications you are now taking:

1: _____ 6: _____

2: _____ 7: _____

3: _____ 8: _____

4: _____ 9: _____

5: _____ 10: _____

Are you allergic to any of the following?

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Anesthetic | ☐ | ☐ | Ibuprofen | ☐ | ☐ | Penicillin |
| ☐ | ☐ | Asprin | ☐ | ☐ | Iodine | ☐ | ☐ | Sulfa |
| ☐ | ☐ | Codeine | ☐ | ☐ | Latex | | | |
| ☐ | ☐ | Other: _____ | | | | | | |

Do you have any of the following medical conditions?

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Asthma | ☐ | ☐ | Joint Replacement | ☐ | ☐ | Psychiatric Treatment |
| ☐ | ☐ | Bleeding Problems | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Cancer | ☐ | ☐ | Liver Disease | ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Pregnancy | ☐ | ☐ | Stroke |
| ☐ | ☐ | Heart Mumur | ☐ | ☐ | Prosthetic Heart Valve | ☐ | ☐ | Ulcers |
| ☐ | ☐ | High Blood Pressure | | | | | | |
| ☐ | ☐ | Other: _____ | | | | | | |

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? _____

**New patients:**

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist: _____ City/State: _____

Date of last cleaning and exam: _____

Is there anything do you not like about your smile? ☐ Black Triangles ☐ Crooked Smile ☐ Discolored Teeth

☐ Other: _____

_____

Parent/Guardian Signature Date: