Regina Mortland Dentistry

CONFIDENTIAL

- CHECK YES OR NO -

PATIENT MEDICAL HISTORY

❑ YES ❑ NO Are you under any medical treatment now?

❑ YES ❑ NO Have you had any major operations? If so, what? _____

❑ YES ❑ NO Have you ever had a serious accident involving head or jaw injuries?

❑ YES ❑ NO Have you had any adverse response to Latex or any drugs, including penicillin and aspirin?

❑ YES ❑ NO Have you ever had any of the following:

❑ Heart Ailment	❑ Diabetes
❑ Any Blood Disease	❑ Any Venereal Disease
❑ High Blood Pressure	❑ Rheumatic Fever
❑ Any Liver Disease	❑ Yellow Jaundice or Hepatitis
❑ Low Blood Pressure	❑ Rheumatism or Arthritis
❑ Any Kidney Disease	❑ Epilepsy
❑ Respiratory Disease	❑ Tumors or Growths
❑ Any Stomach or Intestinal Disease	❑ AIDS

❑ YES ❑ NO Are you on a diet at this time?

❑ YES ❑ NO Are you now taking drugs or medications?

❑ YES ❑ NO Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?

❑ YES ❑ NO Do you have any reason to suspect you are NOT in good health?

❑ YES ❑ NO Have any wounds healed slowly or presented other complications?

❑ YES ❑ NO Are you pregnant?

❑ YES ❑ NO Do you have a history of fainting?

❑ YES ❑ NO Have you ever had any x-ray treatments (other than diagnostic)?

❑ YES ❑ NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?

❑ YES ❑ NO Does your physician require you to take ANTIBIOTICS for your dental visits? (PRE-MED)

CURRENT MEDICATIONS/REASON	DATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature _____ Date _____

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CONFIDENTIAL PATIENT MEDICAL HISTORY PAGE 2

- CHECK YES OR NO -

PATIENT DENTAL HISTORY

❑ YES ❑ NO Do you have any specific problems?

❑ YES ❑ NO Do you have pain in or near your ears?

❑ YES ❑ NO Do you have any unhealed injuries or inflamed areas in or around your mouth?

❑ YES ❑ NO Have you experienced any growth or sore spots in your mouth?

❑ YES ❑ NO Does any part of your mouth hurt when clenched?

❑ YES ❑ NO Have you ever had Novocaine anesthetic?

❑ YES ❑ NO Any reactions or allergic symptoms to Novocaine?

❑ YES ❑ NO Any difficult extractions in the past?

❑ YES ❑ NO Have you had prolonged bleeding following extractions in the past?

❑ YES ❑ NO Do your gums bleed?

❑ YES ❑ NO Do you habitually clench your teeth during the night or day?

❑ YES ❑ NO Any part of your mouth sore to pressures or irritants (cold, sweets, etc.) If so, locate: _____

❑ YES ❑ NO Have you ever been instructed in the correct method of brushing your teeth?

❑ YES ❑ NO Have you ever been instructed on the care of your gums?

❑ YES ❑ NO When was your last full mouth x-ray taken? _____

Where? _____

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Print Name _____ **Signature** _____

Date _____

RECERTIFICATION: I certify that there have been no changes in my health except as noted below.

_____