SHELBY DENTAL

FAMILY — COSMETIC

Medical + Dental History

MEDICAL INFORMATION

Are you currently under the care of a physician? If yes, please explain _____

Name of physician _____ Phone # _____

Have you ever had a serious illness or accident? If yes, please explain _____

List all drugs and medications that you are currently taking _____

_____

_____

_____

Please circle your current physical health: excellent good fair poor

Emergency contact _____ Phone # _____

Circle any of the following which you have had or currently have:

Allergies
Anemia
Angina
Arthritis
Artificial Heart Valve
Artificial Hip/Knee
Asthma/Hay/Fever
Blood Transfusion
Cancer
Cold Sores
Congenital Heart Disease
Diabetes
Drug/Alcohol Addiction
Emphysema
Epilepsy
Fainting Spells
Fever Blisters
Glaucoma
Heart Attack
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis A B C
High Blood Pressure
HIV/AIDS
Kidney Disease
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pacemaker
Pain in Jaw Joints
Psychological Counseling
Rheumatic Fever
Scarlet Fever
Sickle Cell Disease
Sinus Trouble
Stroke
Ulcers
Unusual Bruising/Bleeding
Venereal Disease
Yellow Jaundice

Women are you:
Pregnant
Taking Birth Control
Taking Hormones
Nursing

Are you allergic to: Codeine Darvocet Erythromycin Ibuprofen Keflex Latex Penicillin Tetracycline Tylenol
Other _____

Have you ever been told by a physician that you should pre-medicate with an antibiotic before appointment?
Yes ____ No ____ If yes, what antibiotic and dosage? _____

DENTAL INFORMATION

Name of your former dentist? _____

Are you aware of a dental problem? Please explain _____

_____

When was your last visit? _____

Describe any problems with past dental care _____

Circle any of the following which you have had or currently have:

Bite Feels Off
Bitegard
Bleeding Gums
Braces
Clenching Teeth
Fever Blisters
Food Collects
Grinding Teeth
Gum Disease
Locked Jaw
Mouth Sores
Noise in Jaw Joint
Smoker
Teeth Hot/Cold Sensitive
Trouble Chewing
Unpleasant Taste/Odor
Wear Dentures/Partials
Wisdom Teeth Removed

I certify the truth of all medical information above:

Patient (Parent/Guardian) Signature _____ Date _____

FOR FUTURE USE

I have read the above and certify that there are no changes to my medical history at this time.

Initials/Date _____ Initials/Date _____ Initials/Date _____
Staff Initials/Date _____ Staff Initials/Date _____ Staff Initials/Date _____