Florissant Dental Care DENTAL/MEDICAL HISTORY

Patient's Name: _____

Are you under a physician's care? _____, If so, for what?_____
Physician's Name: _____ Phone number: _____
Do you use tobacco? _____ Do you Clench or grind your teeth? _____
Do you have difficulty opening your mouth? ____ Have you had prolonged bleeding after extractions? _____
Do you need to premedication before any dental appointment? _____
If you are a woman, are you pregnant? _____

Please mark items below if you have or have had any of the following:

__ AIDS/HIV
__ Seasonal Allergies
__ Alzheimer's
__ Anemia
__ Angina
__ Arthritis/Gout
__ Artificial Heart Value
__ Artificial Joint
__ Asthma
__ Blood Disease
__ Breathing Problems
__ Bruise Easily
__ Cancer
__ Chemotherapy
__ Chest Pains
__ Cold Sores/Fever Blisters
__ Congenital Heart Disease
__ Diabetes
__ Epilepsy/Seizures
__ Excessive Bleeding
__ Fainting/Dizziness
__ Frequent Headaches
__ Glaucoma
__ Heart Attack/Failure
__ Heart Murmur
__ Pace Maker
__ Heart Trouble/Disease
__ Hepatitis A
__ Hepatitis B or C
__ High Blood Pressure
__ Irregular Heartbeat
__ Kidney Disease
__ Leukemia
__ Liver Disease
__ Low Blood Pressure
__ Lung Disease
__ Mitral Valve Prolapse
__ Radiation Treatment
__ Renal Dialysis
__ Rheumatic Fever
__ Scarlet Fever
__ Shingles
__ Sickle Cell Disease
__ Sinus Trouble
__ Stomach/Intestinal Disease
__ Stroke
__ Thyroid Disease
__Tonsillitis
__ Tuberculosis
__ Ulcers
__ Other: _____

Are you allergic or have you reacted adversely to any of the following medications:

__ Aspirin
__ Iodine
__ Sedatives
__ Any Metals (Nickel, Mercury)
__ Barbiturates
__ Latex
__ Sulfa Drugs
__ Codeine
__ Local Anesthetics
__ Tetracycline
__ Erythomycin
__ Penicillin

What medication are you currently taking: Please provide a separate list if possible

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Consent:
The undersigned herby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also, authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.
Patient's signature: _____ Date: _____