

# MEDICAL INFORMATION

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Have you come to this office for the relief of pain? \_\_\_\_\_ Yes \_\_\_\_\_ No

If 'yes', where is the pain \_\_\_\_\_

Have you been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has a dentist or hygienist shown you how to clean your teeth? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have sores, swelling, or blisters on your gums, cheeks, or lips? \_\_\_\_\_ Yes \_\_\_\_\_ No

If 'yes', have they been present longer than 3-4 weeks? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you had orthodontic treatment to straighten your teeth? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had an unusual reaction to dental anesthesia? \_\_\_\_\_ Yes \_\_\_\_\_ No

If 'yes', more than once? \_\_\_\_\_ Yes \_\_\_\_\_ No Date of last occurrence \_\_\_\_\_

Date of last medical examination \_\_\_\_\_

Following injuries or dental treatment, have you had bleeding problems? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is there a history of diabetes in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you thirsty most of the time? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you recently lost weight unintentionally (with a good appetite)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you urinate more than six times a day? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you had eye trouble recently? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do injuries or cuts take longer to heal now than they did previously? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your mouth feel dry or do you have burning sensation of lips or tongue? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you taken or been given injections of steroids such as cortisone? \_\_\_\_\_ Yes \_\_\_\_\_ No

## Make a checkmark beside the following only if your answer is 'Yes':

Have you become sick from, shown an allergy to, or been told **not** to take:

- Antibiotics (penicillin, etc.)
- Codeine
- Novocaine or other dental anesthetics
- Other drugs or medicines \_\_\_\_\_

Are you now taking or using medicines for:

- Diabetes (pills or 'shots')
- Nerves (tranquilizers)
- Sleeping
- Heart or blood pressure (digitalis, nitroglycerin, reserpine)
- Blood (liver or iron pills, etc.)
- Stomach trouble (ulcer or other)
- Headaches
- Arthritis or rheumatism
- Allergy

Are you now

- Pregnant
- On a prescribed diet
- Using thyroid
- Using hormones (including birth control pills)

- Using anticoagulents
- Using Dilantin
- Using other medicines \_\_\_\_\_

Have you ever had any of the following?

- Heart disease
- Shortness of breath without exercise or when lying down
- Swelling of ankles or feet
- Pain, pressure, or tight feeling in chest
- Heart attack
- Rheumatic fever
- High blood pressure
- Fainting spells, convulsions, epilepsy
- Frequent headaches (two or three a week)
- Headaches when lying down
- Nervous breakdown, psychotherapy
- Lung trouble (TB, asthma, emphysema)
- Hepatitis, liver disease, jaundice
- Arthritis, sore joints
- HIV virus or AIDS
- Diabetes
- Excessive bleeding
- Blood trouble, anemia, leukemia
- VD (syphilis, gonorrhea)
- X-ray, radium, or cobalt treatments