ROGERS FAMILY DENTAL
MEDICAL HISTORY

PATIENT NAME: ___________________________________ Date of Birth: ___________

Medical Doctor's Name____
Medical Doctor's Phone No. _________________ Date of last Exam__________

PLEASE ANSWER ALL OF THE QUESTIONS BELOW AND PROVIDE EXPLANATION WHERE APPLICABLE:

1. Do you consider yourself to be in good health? ……………………………….……...…YES NO
2. Are you now or within the past year have you been under a physician's care?……………YES NO
   If yes, specify condition being treated for____
3. Do you take any medications?..YES NO
   Please specify name and purpose of medications: ______________________________________
   ____
   ____
4. Have you ever had:

___Rheumatic Fever	___ Heart Attack	___Pacemaker	___Stent
___High Blood Pressure	___Blood Thinners	___Blood Disorder	___Asthma
___Respiratory Problems	___Diabetes	___Tuberculosis	___Rheumatism
___Arthritis	___Kidney Disease	___Thyroid	___Anemia
___Cancer	___Radiation Therapy	___Seizures	___Depression
___ADD/ADHD	___Anxiety	___Hepatitis	__ Liver Disease
___Venereal Disease	___Immune System Disorders		
___Joint Replacement			

   ___Other disease? If so, please Specify______________________________________
   ____
5. Does your physician require antibiotic pre-medication for a heart condition, artificial valve or artificial joint before dental appointments?...YES NO
   If yes, treating doctor's name and phone number____
   Medication prescribed: ____
6. Do you have or have you ever had any heart or blood problems?..YES NO
7. Have you ever been told that you have a heart murmur?...YES NO
8. Do you bleed or bruise easily?..YES NO
9. Have you ever had unusual reactions to or are you allergic to any of the following:
   ___Penicillin ___Amoxicillin ___Aspirin ___Acetaminophen ___Ibuprofen ___Codeine
   ___Barbiturates ___Sulfa Drugs ___Latex
10. Do you have any other allergies to medications? Y/N If Yes, please describe:_________________
11. Are you subject to fainting...____ YES NO
12. Have you ever been diagnosed as being HIV positive or having AIDS?................................YES NO
13. Have you ever had a nervous breakdown or undergone psychiatric treatment?...................... YES NO

14. Have you ever taken Phen-Fen or similar appetite suppressants?... YES NO
    If Yes, have you seen your physician or cardiologist for a cardiac evaluation?.................... YES NO
15. Have you ever used or are you now using tobacco, E-cigarettes, or alcohol?......................... YES NO
16. Have you ever received counseling for use of alcohol and/or prescription drugs?................. YES NO
17. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease.
    the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? ....YES NO
18. Women Only: Are you pregnant? _______ Are you nursing? _______ Birth control pills? ________

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location____

1. How long ago did you last see a dentist? ___________________________
2. Do you have tooth related pain? …………………………………………………………..…YES NO
3. Are your teeth sensitive to: ___Cold ___Hot___ Sweets ____Biting/Pressure
4. Do you think your teeth are affecting your general health in any way?.................................YES NO
5. Do you have or have you ever had bleeding or sensitive gums?..YES NO
6. Have you had any head, neck or jaw injuries?...YES NO
7. Have you ever had any severe reactions to dental treatment or local anesthetics?................YES NO
8. Are you allergic to any local anesthetics?..YES NO
   If yes, please specify:____
9. Do you like your smile? Y/N If not, what would you change? ____________________________
   ____

Place a checkmark if you have experienced the following:

_____Clicking with your jaw
_____Pain (joint, ear, side of face)
_____Difficulty in opening or closing your mouth
_____Difficulty in chewing
_____Frequent headaches
_____Clenching or grinding your teeth
_____Biting your lips or cheeks frequently

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES TO THIS INFORMATION AT ANY SUBSEQUENT APPOINTMENT.

Signature____ Date____________________
(Patient, legal guardian or authorized agent of patient)