Tri-County Dental Medical History

Patient Name:_________________________ Birth Date_________________

Please complete the following information based on the Medical and Dental Health History of the above named patient.

Please Circle YES or NO.

1. Are you under a physician's care now? YES NO
   Physician's Name: ____
   Have you ever been hospitalized or had a major operation? YES NO
   If yes please explain____
2. Have you ever had a serious head or neck injury? YES NO
   If yes please explain____
3. Are you taking any medications, pills, or drugs (including vitamins)? YES NO
   If yes, please list____
4. Do you have any Allergies? Please **circle:** NO YES - MEDICATIONS LATEX METAL FOOD
   If yes please explain and reactions____
5. Do you use tobacco? YES NO
   If yes, how many cigarettes do you smoke per day? _______ How many years have you been smoking? _______
   Do you use controlled substances/recreational drugs? YES NO
   If yes, please list ____
   Do you drink alcohol? YES NO
   How many drinks per week? ______________
6. Are you in pain today inside your mouth? YES NO
   If Yes Explain:____

WOMEN (Please Circle Yes or NO**)**: 1. Are you pregnant or is there a chance you may be pregnant? YES NO 2.Due Date:_______________________
3. Taking oral contraceptives? YES NO 4. Nursing? YES NO

Please circle **YES or NO** if you have or have you ever had any of the following diseases or medical problems?

Coronary Artery Disease	Y	N	Arthritis	Y	N	Artificial Joints/Implants	Y	N
Mitral Valve Prolapse	Y	N	Bulimia	Y	N	Rheumatoid Arthritis	Y	N
Heart Murmur	Y	N	Anorexia	Y	N	AIDS or HIV+	Y	N
Heart Valve Surgery	Y	N	Chronic Pain Syndrome	Y	N	Night Sweats	Y	N
Chest Pain / Angina	Y	N	Osteoporosis	Y	N	Persistent Swollen Glands	Y	N
Pacemaker	Y	N	Gastrointestinal Disease	Y	N	Infectious Mononucleosis	Y	N
Heart Bypass Surgery	Y	N	Cold Sores/Ulcers in Mouth	Y	N	Recurrent Infections	Y	N
Congestive Heart Failure	Y	N	German Measles/Rubella	Y	N	Hemophilia	Y	N
Heart Disease	Y	N	Tuberculosis	Y	N	Anemia	Y	N
Rheumatic Fever	Y	N	Asthma	Y	N	Cancer/Malignancy	Y	N
Stroke	Y	N	Lung/Respiratory Disease	Y	N	Chemo/Radiation Therapy	Y	N
Systemic Lupus	Y	N	Immune Deficiency	Y	N	Bisphosphonate Use	Y	N
High Blood Pressure	Y	N	Sinus Problems	Y	N	Mental Disorders	Y	N
Low Blood Pressure	Y	N	Hay Fever/Allergies	Y	N	Neurological Disorders	Y	N
Diabetes	Y	N	Hives or Rash	Y	N	Sleep Disorder	Y	N
Glaucoma	Y	N	Seizures	Y	N	Hearing Loss	Y	N
Epilepsy	Y	N	Bleeding Disorders	Y	N	Severe Headache/Migraine	Y	N
Thyroid Problems	Y	N	Fainting Spells	Y	N	Jaundice	Y	N
Kidney Problems	Y	N	Stomach Ulcers	Y	N	Acid Reflux/Heartburn	Y	N
Hepatitis (Type: ____)	Y	N	Liver Disease	Y	N	Infective Endocarditis	Y	N

Do you require Antibiotic Pre-Medication prior to any dental treatment? Y N

Do you have any disease, condition, or problem not listed above that you think the doctor should be aware of? Y N

If yes, please explain ____

Please note: *You are encouraged to discuss any and all relevant patient health issues prior to treatment.* **I certify that I have read and understand the above. I acknowledge that my questions, if any, about the information above have been answered to my satisfaction. I will not hold Tri- County Community Action Agency, my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.**

____ ___________________________

Signature of Patient, Parent or Guardian **Date**

____ ___________________________

Signature of Provider (Reviewed by) **Date**