ATLANTIS DENTAL
FAMILY & COSMETIC DENTISTRY

PATIENT MEDICAL HISTORY

Clear Form | Print

Patient's name: _____ Date of birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health	○	○
2. Have there been any changes in your health within the past year	○	○
3. Date of your last physical exam _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician	○	○
6. Have you ever been hospitalized for any surgical operation or serious illness Please explain _____	○	○
7. Are you taking any medicine(s) including non-prescription medicine If yes, what medicine(s) are you taking _____	○	○
8. Have you had any abnormal bleeding	○	○
9. Do you bruise easily	○	○
10. Have you ever required a blood transfusion	○	○
11. Have you had a recent weight loss	○	○
12. Have you ever taken Fen-Phen or Redux	○	○
13. Do you use tobacco	○	○
14. Do you or have you used controlled substances	○	○
15. Are you wearing contact lenses	○	○
16. Do you have any disease, condition or problem not listed above you think I should know about	○	○
Are you allergic to or have you had reactions to:		
Local anesthetics like novocaine	○	○
Penicillin or other antibiotics	○	○
Sulfa drugs	○	○
Barbiturates, sedatives or sleeping pills	○	○
Aspirin	○	○
Iodine	○	○
Any metals (e.g. nickel, mercury, etc.)	○	○
Latex / rubber	○	○
Other (please list) _____		
WOMEN ONLY		
Are you pregnant or think you may be pregnant	○	○
Are you nursing	○	○
Are you taking birth control pills	○	○

Do you have or have you ever had the following: — Check if applicable

- ☐ Rheumatic heart disease or Rheumatic fever
- ☐ Scarlet fever
- ☐ Heart defect or heart murmur
- ☐ Heart trouble, heart attack or Angina
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pacemaker
- ☐ Heart surgery
- ☐ High/low blood pressure
- ☐ Congenital heart problem
- ☐ Swelling of feet, ankles, hands
- ☐ Hepatitis, jaundice or liver disease
- ☐ Stroke
- ☐ Sinus trouble
- ☐ Lung or breathing problems
- ☐ Asthma or hay fever
- ☐ Hives or skin rash
- ☐ Fainting or dizzy spells
- ☐ Diabetes
- ☐ AIDS or HIV infection
- ☐ Thyroid problems
- ☐ Allergies
- ☐ Arthritis or Rheumatism
- ☐ Joint replacement or implant
- ☐ Stomach ulcer
- ☐ Kidney trouble
- ☐ Tuberculosis
- ☐ Persistent cough
- ☐ Cough that produces blood
- ☐ Chemotherapy (cancer, leukaemia)
- ☐ Sexually transmitted disease
- ☐ Epilepsy or seizures
- ☐ Anemia
- ☐ Glaucoma
- ☐ Nervousness
- ☐ Tonsillitis
- ☐ Tumors
- ☐ Mental health care
- ☐ Back problems
- ☐ Chemical dependency
- ☐ Mitral valve prolapse
- ☐ Cortisone treatment
- ☐ Cold sores/fever blisters
- ☐ Hypoglycaemia
- ☐ Eating Disorder