ROCKPORT FAMILY DENTAL

227 MAIN STREET; ROCKPORT, MA 01966

Medical History Pg.1 Date: ____________________

Patient Name: ____ Birth Date: ____________________

Are you under a physician's care now? Yes ___ No___ If yes, please explain: ____________________

____

Have you ever been hospitalized or had a major operation? Yes ___ No___ If yes, please explain:

____

Have you ever had a serious head or neck injury? Yes ___ No___ If yes, please explain: ___________

____

Are you taking any prescription drugs? Yes ___ No___ If yes, please list: _______________________

____

Do you need to pre-medicate with an antibiotic prior to dental appointments? Yes ____No____
If yes, what for? ____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes ___ No ___

Are you allergic to any of the following? Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___
Latex ___ Local Anesthetics ___ Sulfa Drugs ___
Other:____

Are you on a special diet? Yes ___ No____ Explain: ____________________________________

____

Pregnant? Yes ___ No ___ Nursing? Yes ___ No ___

Taking Oral Contraceptives? Yes ___ No ___

Do you use tobacco? Yes ___ No ___ Smoke ____ Chew____ Do you Vape? Yes ___ No ___

Do you use controlled substances? Yes ___ No___

Do you have or had, any of the following? (Please Circle)

AIDS * HIV Positive * Diabetes * Herpes * Rheumatic Fever * Neurological Disorders * Alzheimer's Disease * Dementia * Drug Addiction * Alcohol Addiction * High Blood Pressure * Rheumatism * High Cholesterol * Scarlet Fever * Anemia * Anaphylaxis * Emphysema * Hives/Rash * Shingles * Angina * Epilepsy * Seizures * Hypoglycemia * Sickle Cell Disease * Arthritis * Gout * Excessive Bleeding * Easily winded * ADD * ADHD * Autism * Asperger's * PTSD

ROCKPORT FAMILY DENTAL   MEDICAL HISTORY Pg. 2

Kidney Problem ∗ Sinus Trouble ∗ Artificial Heart Valve ∗ Fainting Spells * Dizziness ∗ Leukemia Spina Bifida ∗ Artificial Joint ∗ Frequent Coughs ∗ Liver Disease ∗ Stroke ∗ Frequent Diarrhea *Low Blood Pressure ∗ Swelling of Limbs ∗ Blood Disease ∗ Frequent Headaches ∗ Lung Disease ∗ Thyroid Disease ∗ Blood Transfusion ∗ Asthma * Glaucoma ∗ Mitral Valve Prolapse ∗ Tonsillitis ∗ Breathing Problems ∗ Hay Fever ∗ Osteoporosis ∗ Tuberculosis ∗ Cancer/Chemotherapy ∗ Ulcers * Heart Attack/Failure ∗ Pain in Jaw Joints/ TMJ ∗ Tumor/Growth ∗ Chest Pain ∗ Heart Murmur ∗ Parathyroid ∗ Cold Sore/Fever Blister ∗ Heart Pacemaker ∗ Psychiatric Care ∗ Venereal Disease ∗ Congenital Heart Disorder ∗ Heart Trouble/Disease ∗ Radiation ∗ Vision Problems ∗ Convulsion ∗ Recent Weight Loss/Gain ∗ Yellow Jaundice ∗ Cortisone Medicine ∗ Renal Dialysis ∗ Hemophilia * Hepatitis A, B, or C ∗ Blood Clot * Anxiety/Panic attacks * Depression

*Additional not listed above:____

____

Are you taking any blood thinners? Yes ____ No____ Which one(s)______________________________

____

When was your last dental visit?__________________ What was done?____________________________

Do your gums bleed while brushing or flossing? Yes ____ No____

Are your teeth sensitive to hot or cold or sweets? Yes ____ No____

If yes, which ones: ____

Do you clench or grind your teeth? Yes ____No____

Any difficulties with extractions in the past? Yes ____No____

Prolonged bleeding? Yes ____ No____

Do you bite your lips or cheeks frequently? Yes ____ No____

Have you experienced any of the following in your jaw (Please check if yes): Clicking ____ Pain (joint, ear, side of face) ____Difficulty in opening ____ closing ____Difficulty chewing____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical history.

Patient/Responsible Party Signature: ______________________________________ Date: _____________