MEDICAL & DENTAL HISTORY

Patient Name:_____ Preferred Name:_____

Phone _____ Email _____

1. Are you currently under the care of a physician? ❑Yes ❑No Physician's Name:_____
   If yes, please explain:_____
2. Are you taking any prescription or over the counter drugs? ❑Yes ❑No
   If yes, please list each one:_____
3. Do you bleed excessively when injured? ❑Yes ❑No
4. **For Women**: Are you pregnant? ❑Yes ❑No Are you nursing? ❑Yes ❑No
   Are you currently taking birth control? ❑Yes ❑No
5. Please (check☑) either Yes or No for all conditions below that you have or have not had:

❑Yes ❑No AIDS/HIV+	❑Yes ❑No *Pre-Med	❑Yes ❑No High Blood Pressure
❑Yes ❑No Arthritis	❑Yes ❑No Pacemaker	❑Yes ❑No Sinus Problems
❑Yes ❑No Asthma	❑Yes ❑No Liver Disease	❑Yes ❑No Siezures
❑Yes ❑No Stroke	❑Yes ❑No Cancer	❑Yes ❑No Kidney Problems
❑Yes ❑No Vertigo	❑Yes ❑No Diabetes	❑Yes ❑No Low Blood Pressure
❑Yes ❑No Tuberculosis	❑Yes ❑No Hepatitis A/B/C	❑Yes ❑No Rheumatic Fever
❑Yes ❑No Heart Problem	❑Yes ❑No Epilepsy	❑Yes ❑No Other

6. If you (checked☑) YES to Heart Problem or Other, please explain: _____
   _____
7. Please (check☑) either Yes or No for all of the items listed below that you may or may not be allergic to:

❑Yes ❑No Aspirin	❑Yes ❑No Penicillin	❑Yes ❑No Sulfa
❑Yes ❑No Erythromycin	❑Yes ❑No Tetracycline	❑Yes ❑No Dental Anesthetic
❑Yes ❑No Codeine	❑Yes ❑No Latex Gloves	❑Yes ❑No Acetaminophen
❑Yes ❑No Metals (Jewelry)	❑Yes ❑No Ibuprofen	❑Yes ❑No Other

8. Please list any other allergies:_____
9. What was your previous dentist's name?_____Date of last visit?_____
10. Have you ever had Periodontal corrections; for example: Gum surgery/ Root Planing/ Deep Cleaning. ❑Yes ❑No.
11. Have you ever had Orthodontic appliances/ Braces/ etc.? ❑Yes ❑No.
12. Do your gums bleed after brushing or flossing? ❑Yes ❑No
13. Do you smoke or chew tobacco? ❑Yes ❑No If yes, how much and/or often?_____
14. Have you ever taken medication for Osteoporosis? ❑Yes ❑No If yes, what?_____
15. Have you had any type of implant placed or joint replacement in the last year ❑Yes ❑No If yes, what? _____

TREATMENT CONSENT

The answers that I have provided are true to the best of my knowledge. In addition, I authorize the doctors and staff of Craftsman Dental Care to provide me with routine dental care including but not limited to radiographs, photographs, diagnostic, prophylactic, preventative and restorative dental procedures.

X

_____

Signature of Patient Date Guardian (if Under 18 Years of Age) Date

Doctor's Signature: _____ Date _____