axiscommunityhealth

# MEDICAL HISTORY

Patient's Name _____ Chart _____

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone # (____) _____ Date of last visit: _____

**Your current physical health is:** ☐ **Good** ☐ **Fair** ☐ **Poor**

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Phen-Fen?
Also known as Redux or Pondimin. ☐ Yes ☐ No

If so, when? _____

Have you ever had any of the following diseases or medical problems:

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Hepatitis |
| Y | N | AIDS | Y | N | Herpes / Fever Blisters |
| Y | N | Alcohol / Drug Abuse | Y | N | High Blood Pressure |
| Y | N | Anemia | Y | N | HIV |
| Y | N | Arthritis | Y | N | Hospitalized for any reason |
| Y | N | Artificial Bones/Joints/Valves | Y | N | Kidney Problems |
| Y | N | Asthma | Y | N | Liver Disease |
| Y | N | Blood Transfusion | Y | N | Low Blood Pressure |
| Y | N | Cancer / Chemotherapy | Y | N | Mitral Valve Prolapse |
| Y | N | Colitis | Y | N | Pacemaker |
| Y | N | Congenital Heart Defect | Y | N | Psychiatric Problems |
| Y | N | Diabetes | Y | N | Radiation Treatment |
| Y | N | Difficulty Breathing | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Emphysema | Y | N | Seizures |
| Y | N | Epilepsy | Y | N | Shingles |
| Y | N | Fainting Spells | Y | N | Sickle Cell Disease / Traits |
| Y | N | Frequent Headaches | Y | N | Sinus Problems |
| Y | N | Glaucoma | Y | N | Stroke |
| Y | N | Hay Fever | Y | N | Thyroid Problems |
| Y | N | Heart Attack / Surgery | Y | N | Tuberculosis (TB) |
| Y | N | Heart Murmur | Y | N | Ulcers |
| Y | N | Hemophilia | Y | N | Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Erythromycin | Y | N | Penicillin |
| Y | N | Codeine | Y | N | Jewelry/Metals | Y | N | Tetracycline |
| Y | N | Dental Anesthetics | Y | N | Latex | Y | N | Other |

Please list any other drugs/materials that you are allergic to: _____

_____

**For Women: Are you taking birth control pills?** ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

# DENTAL HISTORY

**Why have you come to the dentist today?** _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

**Your current dental health is:** ☐ **Good** ☐ **Fair** ☐ **Poor**

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush Daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ Discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Date of last exam and x-rays _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorized the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____
Signature Date

**Blood Pressure**_____/_____
**Weight**_____

**OFFICE USE ONLY** **OFFICE USE ONLY**

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

**Doctor's Comments**: _____

_____

_____

_____

# MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit: ☐ Yes ☐ No

If Yes, Please explain: _____

Has there been any change in your health status since your last visit? ☐ Yes ☐ No

If Yes, please explain: _____

_____
Patient Signature Date

_____
Dentist Signature Date

_____
Patient Signature

_____
Dentist Signature Date