PATRICIA CONN, DDS
COMPREHENSIVE DENTISTRY

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NEW PATIENT MEDICAL HISTORY

Name _____ Today's Date _____

Primary Care Physician's Name _____ Date of last medical exam _____

Have you ever been hospitalized or had a major operation? ❑ Yes (Explain) _____ ❑ No

Have you ever had a serious head or neck injury? ❑ Yes (Explain) _____ ❑ No

List all medications you are currently taking including over the counter supplements/medications:

_____

_____

Have you ever taken Phen-Fen or Redux? ❑ Yes (Explain) _____ ❑ No

Have you ever taken Foxamax, Boniva, Actonel or any bisphosphonates? ❑ Yes (Explain) _____ ❑ No

Have you ever been told that you need an antibiotic premedication prior to dental treatment? ❑ Yes ❑ No

Do you or have you used tobacco? ❑ Yes ❑ No …or used any controlled substance? ❑ Yes ❑ No

Females, are you: ❑ Pregnant or trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives

Are you allergic to any of the following:

❑ Aspirin	❑ Penicillin	❑ Codeine	❑ Acrylic	❑ Other?
❑ Metal	❑ Latex	❑ Sulfa Drugs	❑ Local Anesthetics	_____

Do you currently have, or have you ever had any of the following (circle all that apply):

AIDS/HIV Positive	Cortisone Topical	Hepatitis B	Renal Dialysis
Alzheimer's/Dementia	Diabetes (Type I or II)	Hepatitis C	Rheumatic Fever
Anaphylaxis	Drug Addiction	High Blood Pressure	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	Hives/Rash	Shingles
Arthritis	Epilepsy or Seizures	Hypoglycemia	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Irregular Heart Beat	Sinus Trouble
Artificial Joint(s)	Excessive Thirst	Kidney Problems	Spina Bifida
Asthma	Fainting Spells/Dizziness	Leukemia	Stomach/Intestinal Disorder
Blood Disease	Frequent Cough	Liver Disease	Stroke
Blood Transfusion	Frequent Headaches	Low Blood Pressure	Swelling of limbs
Breathing Problems	Glaucoma	Lung Disease	Thyroid Disease
Bruise Easily	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Cancer	Heart Attack/Failure	Osteoporosis	Tuberculosis
Chemotherapy	Heart Murmur	Pain in Jaw Joints	Tumors/Growths
Chest Pains	Heart Pacemaker	Parathyroid Disease	Ulcers
Cold Sores/Fever Blisters	Heart Trouble/Disease	Psychiatric Care	Venereal Disease
Congenital Heart Disorder	Hemophilia	Radiation Treatment	Yellow Jaundice
Convulsions	Hepatitis A	Recent Weight Loss	Multiple Sclerosis
Cortisone Injections			

Reason for today's visit _____ Previous Dentist _____

Approx. date of last dental visit _____ Date of last x-rays _____

Do you currently have, or have you ever had any of the following (Check all that apply):

❑ Bad breath	❑ Grinding teeth	❑ Sores or growths in mouth	❑ Sensitivity to heat/cold
❑ Bleeding gums	❑ Clicking or popping jaw	❑ Food collection between teeth	❑ Sensitivity to sweets
❑ Dental Anxiety	❑ Loose teeth or broken fillings	❑ Periodontal (gum) treatment	❑ Sensitivity when chewing

How often do you floss? _____ How often do you brush? _____

Is there anything about the appearance of your teeth/gums that you would like to change? _____

Do you have other concerns about your teeth/gums/oral health? _____

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 health. It is my responsibility to inform my provider of any changes in medical status. .

Signature of Patient, Parent or Guardian _____