MEDICAL HEALTH INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Do you have or have you had any of the following?
(Please check those that apply)

- ❑ AIDS
- ❑ Allergies _____
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joint or Valve
- ❑ Asthma
- ❑ Blood Disease
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Cold Sores/Fever Blisters
- ❑ Diabetes
- ❑ Diet (Special/Restricted)
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Glaucoma
- ❑ HIV Positive
- ❑ Headaches Migraine or Frequent Headaches
- ❑ Heart (Attack, Disease, Surgery)
- ❑ Heart Murmer
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Radiation Treament
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Sexully Transmitted Disease
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Do you use controlled substances? ❑ yes ❑ no

Are you currently under medical treatment? ❑ yes ❑ no

Are you taking any medication(s) including non-prescription medicine? ❑ yes ❑ no
If Yes, please list:

_____

_____

	Yes	No
Do your gums bleed while brushing or flossing?	❑	❑
Are your teeth sensitive to sweet or sour liquids/food?	❑	❑
Do you have any sores or lumps in or near your mouth?	❑	❑
Have you ever experienced any of the following problems In your jaw?		
Clicking	❑	❑
Pain (Joint, Ear, Side of Face?)	❑	❑
Difficulty in opeing or closing?	❑	❑
Difficulty in chewing?		

	Yes	No
Are your teeth sensitive to hot or cold liquids/food?	❑	❑
Do you feel pain to any of your teeth?	❑	❑
Have you had any head, neck, or jaw injuries?	❑	❑
Do you clench or grind your teeth?	❑	❑
Have you had any difficult extractions in the past?	❑	❑
Prolonged bleeding following extractions?	❑	❑
Do you wear dentures or partials?	❑	❑
if yes, date of placement:_____		

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, I understand providing incorrect information can be dangerous to my health. I authorize Snyder Family Dentistry to realease any information including the diagnosis and record of any treatment or examination rendered to me or my child to third party payors and/or heath practioners.

Signature of patient (or parent) _____ Date _____