MEDICAL HISTORY

JUSTIN BEASLEY D.D.S.

Patient Name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, for what & Doctor's name_____

Have you ever been hospitalized or had a major operation? O Yes O No If yes, explain_____

Have you ever had a serious head or neck injury? O Yes O No If yes, explain_____

Are you taking any medications, pills, or drugs? O Yes O No If yes, please ***LIST***:_____

Do you take, or have you taken Biphosphonates, (such as Fosamax, Boniva, etc) Phen-Fen or Redux? O Yes O No _____

Are you on a special diet? O Yes O No _____

Do you use tobacco? O Yes O No _____

Do you use controlled substances? O Yes O No _____

Do you like the appearance and color or your teeth? O Yes O No If no, explain _____

Do your gums bleed when brushing or flossing? O Yes O No _____

How long has it been since your teeth have been professionally cleaned?_____

Women: Are you…

Pregnant/Trying to get pregnant? Yes O Taking oral contraceptives? Yes O Nursing? Yes O

Are you allergic to the following? (Circle all that apply)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other, please LIST:_____

Do you have, or have you had, any of the following?

AIDS/HIV positive	O	Diabetes	O	Hepatitis B or C	O	Renal Disease	O
Alzheimer's disease	O	Drug Addiction	O	Herpes	O	Rheumatic Fever	O
Anaphylaxis	O	Easily Winded	O	High Blood Pressure	O	Rheumatism	O
Anemia	O	Emphysema	O	High Cholesterol	O	Scarlett Fever	O
Angina	O	Epilepsy or Seizures	O	Hives or Rash	O	Shingles	O
Arthritis/Gout	O	Excessive Bleeding	O	Hypoglycemia	O	Sickle Cell Disease	O
Artificial Heart Valve	O	Excessive Thirst	O	**Irregular Heartbeat**	O	Sinus Trouble	O
Artificial Joint	O	Fainting Spells/Dizziness	O	Kidney Problems	O	Spina Bifida	O
Asthma	O	Frequent Cough	O	Leukemia	O	Stomach/Intestinal Disease	O
Blood Disease	O	Frequent Diarrhea	O	Liver Disease	O	Stroke	O
Blood Transfusion	O	Frequent Headaches	O	Low Blood Pressure	O	Swelling of Limbs	O
Breathing Problems	O	Genital Herpes	O	Lung Disease	O	Thyroid Disease	O
Bruise Easily	O	Glaucoma	O	**Mitral Valve Prolapse**	O	Tonsillitis	O
Cancer	O	Hay Fever	O	Osteoporosis	O	Tuberculosis	O
Chemotherapy	O	**Heart Attack/Failure**	O	Pain in Jaw Joints	O	Tumors or Growths	O
Chest Pains	O	**Heart Murmur**	O	Parathyroid Disease	O	Ulcers	O
Cold Sores/ Fever Blisters	O	**Heart Pace Maker**	O	**Prosthetic Heart Valve**	O	Venereal Disease	O
Congenital Heart Disorder	O	**Heart Trouble/Disease**	O	Psychiatric Care	O	Yellow Jaundice	O
Convulsions	O	Hemophilia	O	Radiation Treatments	O		
Cortisone Medicine	O	Hepatitis A	O	Recent Weight Loss	O		

I have none of the above medical conditions O

If yes to any above or if any serious illness not listed, please explain_____

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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 status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE_____