Oak Ridge Family Dental

Medical History:

Patient Name _____

Physician Name _____

Date of Last Visit _____

Do you Smoke? _____ Yes _____ No
Drink > 2 drinks/day? _____ Yes _____ No
Use Recreational Drugs _____ Yes _____ No
If yes, please describe _____

Women Only:

Are you pregnant? _____Yes _____ No

Are you currently nursing? _____Yes _____ No

Do you take Birth Control? _____ Yes _____ No

Are You allergic to Latex, which is used in many dental products including gloves
_____ Yes _____ No

Please list any medications you are currently taking _____
_____
_____

Please list any allergies you may have _____

Indicate which of the following you have had, or have at present (check all that apply)

___ Allergies or Hives
___ Anemia
___ Anxiety Problems
___ Arthritis
___ Artificial Heart Valves
___ Artificial Joints
___ Asthma
___ Back Problems
___ Blood Disease
___ Cancer
___ Chemical Dependency
___ Chemotherapy
___ Circulatory Problems
___ Cold Sores
___ Congenital Heart Defect
___ Diabetes
___ Epilepsy
___ Fainting
___ Gastric Reflux
___ Glaucoma
___ Headaches
___ Heart Murmur
___ Heart Attack
___ Heart Problems
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ HIV Positive
___ Jaw Pain
___ Kidney Problems
___ Liver Disease
___ Mitral Valve Prolapse
___ Neurological Problems
___Pacemaker/Defibrillator
___ Psychiatric Care
___ Radiation Treatment
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Sinus Problems
___ Skin Rash
___ Snoring
___ Stroke
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Ulcers
___ STD'S _____

___ Other/Please Describe _____

_____

Have you had surgery or been hospitalized in the last 5 years ___ Yes ___ No Please describe:
_____
_____