Rockridge Smiles
The Peterson Chan Dental Group

Medical History

NAME ______________________________ DATE ______________________________

In order to give you complete dental health care, please answer the following questions. Your reply will be kept in strict confidence.

General Health (please check): Excellent ❑ Good ❑ Fair ❑ Poor ❑

Name of Physician :____ Are you being treated by a physician now? Yes ❑ No ❑

Last complete physical? ____________________________________ Have you recently been hospitalized? Yes ❑ No ❑

Are you taking any medication now? Yes ❑ No ❑ List medication ____

____

Check "yes" or "no" for all of the following conditions that you might have had or might have at present:

	Yes	No		Yes	No		Yes	No		Yes	No
Infective Endocarditis	❑	❑	Heart Surgery	❑	❑	Arthritis	❑	❑	Drug Addiction	❑	❑
Heart Disease or Attack	❑	❑	Artificial Joint	❑	❑	Cortisone Medicine	❑	❑	Hemophilia	❑	❑
Angina Pectoris	❑	❑	Anemia	❑	❑	Glaucoma	❑	❑	Venereal Disease	❑	❑
High Blood Pressure	❑	❑	Stroke	❑	❑	Anorexia / Bulimia	❑	❑	Cold Sores	❑	❑
Heart Murmur	❑	❑	Kidney Trouble	❑	❑	AIDS / HIV	❑	❑	Herpes Virus	❑	❑
Rheumatic Fever	❑	❑	Ulcers	❑	❑	Immuno Suppressed	❑	❑	Epilepsy or Seizures	❑	❑
Congenital Heart Lesions	❑	❑	Emphysema	❑	❑	Hepatitis A (infectious)	❑	❑	Fainting or Dizzy Spells	❑	❑
Mitral Valve Prolapse	❑	❑	Tuberculosis (TB)	❑	❑	Hepatitis B (serum)	❑	❑	Psychiatric Treatment	❑	❑
Scarlet Fever	❑	❑	Asthma	❑	❑	Hepatitis C	❑	❑	Sickle Cell Disease	❑	❑
Artificial Heart Valve	❑	❑	Sinus Trouble	❑	❑	Liver Disease	❑	❑	Bruise Easily	❑	❑
Heart Pacemaker	❑	❑	Diabetes	❑	❑	Cancer / Chemo	❑	❑	GERD	❑	❑

Have you ever taken Phen-Fen / Redux? Yes ❑ No ❑

Are you allergic to Penicillin ❑ Codeine ❑ Local Anesthetic ❑ Latex ❑ Other medications ❑ _______________

Are you subject to prolonged bleeding? Yes ❑ No ❑ Are you subject to fainting spells? Yes ❑ No ❑

Women: Are you pregnant? Yes ❑ No ❑ Expected due date: ______________________

Do you have any sensitivity to metals? Yes ❑ No ❑

Do you use tobacco? Yes ❑ No ❑

Dental History

Date of last dental visit?______________ What was done then? ____________________

Have you had dental X-rays in the past 3 years ___________________________________

How often do you brush your teeth? _________________ Floss? __________________

Yes	No	
❑	❑	Are you satisfied with the appearance of your teeth?
❑	❑	Are you in dental pain now?
❑	❑	Are there any growths or sores in your mouth?
❑	❑	Do your gums bleed?
❑	❑	Have you ever had periodontal treatment?
❑	❑	Do you have sensitive teeth?
❑	❑	Are you aware of clenching or grinding your teeth?
❑	❑	Do you have discomfort or sounds in your jaw joint when you open wide?
❑	❑	Have you had orthodontic treatment?
❑	❑	Do you feel nervous about having dental treatment?

Office Use
Medical History Update

Please add anything you feel is important for the doctor to know about your present health ______________________

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Do you have any special requests that would make your visits more pleasant, such as ear phones, nitrous oxide gas, short or long visits etc. ____

Signature____