



Maupin & Brown
Dentistry

PATIENT MEDICAL HISTORY

Physician _____ City _____ Date of Last Exam _____

Are you under medical treatment now? Yes No

Are you currently taking medication(s)? Yes No

If yes, please list all taken: _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Have you ever taken any class of drugs known as bisphosphonates? Yes No

(They are generally prescribed to prevent/treat osteoporosis or cancer. Examples: Fosamax, Actonel, Aredia, Zoqueat & Boniva)

Are you allergic to any of the following?

| | | | |
|----------------------------------|--|---------------------------|--|
| Latex Rubber | <input type="checkbox"/> Yes <input type="checkbox"/> No | Local Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ibuprofen | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or Amoxicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tylenol (Acetaminophen) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sedatives (etc. Valium or Xanax) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Peanuts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (please list) _____ | |

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

| | | | |
|-----------------------------------|--|---------------------------|--|
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Joint Replacement or Implant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pains/Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis/Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, do you take methotrexate? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If so, please list: _____ | |

Women Only:

Are you pregnant or think you may be pregnant? Yes No

Are you nursing? Yes No

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ City _____ Date of Last Exam _____

| | | | |
|--|--|--|--|
| Do your gums bleed when brushing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are your teeth sensitive to hot or cold? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have had any difficult extractions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you clench or grind your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any sores or lumps in your mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had prolonged bleeding following extractions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you feel especially anxious at the dentist? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Thank You!