Maupin & Brown Dentistry

PATIENT MEDICAL HISTORY

Patient Name _____ Date of Birth _____
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	❑ Yes ❑ No	Local Anesthetics	❑ Yes ❑ No
Ibuprofen	❑ Yes ❑ No	Penicillin or Amoxicillin	❑ Yes ❑ No
Tylenol (Acetaminophen)	❑ Yes ❑ No	Aspirin	❑ Yes ❑ No
Sedatives (etc. Valium or Xanax)	❑ Yes ❑ No	Codeine	❑ Yes ❑ No
Peanuts	❑ Yes ❑ No	Other (please list)_____	

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

Diabetes	❑ Yes	❑ No	Stroke If so, when _____	❑ Yes	❑ No
Lupus	❑ Yes	❑ No	Heart Attack If so, when _____	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Joint Replacement or Implant	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No
Liver Disease	❑ Yes	❑ No	Chest Pains/Angina	❑ Yes	❑ No
Hepatitis/Jaundice	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No
Fainting/Seizures	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No
Epilepsy/Convulsions	❑ Yes	❑ No	Leukemia	❑ Yes	❑ No
Thyroid Problem	❑ Yes	❑ No	AIDS or HIV	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Cardiac Pacemaker	❑ Yes	❑ No
Osteoporosis	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No
Rheumatoid Arthritis	❑ Yes	❑ No	Stomach Ulcers	❑ Yes	❑ No
If yes, do you take methotrexate?	❑ Yes	❑ No	Other Condition(s) we should be aware of?	❑ Yes	❑ No
Cancer	❑ Yes	❑ No			
Type: _____ Date: _____			If so, please list:_____		
Radiation or Chemotherapy?	❑ Yes	❑ No			
Explain: _____			_____		

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?	❑ Yes ❑ No	Are your teeth sensitive to hot or cold?	❑ Yes ❑ No
Do you have frequent headaches?	❑ Yes ❑ No	Have had any difficult extractions?	❑ Yes ❑ No
Do you clench or grind your teeth?	❑ Yes ❑ No	Do you have any sores or lumps in your mouth?	❑ Yes ❑ No
Have you had prolonged bleeding following extractions?	❑ Yes ❑ No	Do you feel especially anxious at the dentist?	❑ Yes ❑ No

Thank You!