procare dental

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No

_____

3. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. **Women:** Are you pregnant Yes No Trying to get pregnant? Yes No Breast feeding? Yes No
7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax, Actonel, Boniva, Aredia, Reclast, Zometa For how long? _____When did you stop? _____

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic Latex Codeine Other Antibiotic: _____
Penicillin Acrylic Metals Other:_____

Please check if you have/had:	Yes	No
AIDS/HIV Positive	☐	☐
Allergies	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis/Rheumatism	☐	☐
Artificial Heart Valves	☐	☐
Artificial Joint(s)	☐	☐
Asthma	☐	☐
Date of last episode	☐	☐
Have you used steroids	☐	☐
Required Hospitalization	☐	☐
Back Pain	☐	☐
Blood Disease/Clotting Disorders	☐	☐
Blood Transfusion	☐	☐
Breathing Problems	☐	☐
Bruise Easily	☐	☐
Cancer Type_____	☐	☐
Canker Sores	☐	☐
Chemotherapy	☐	☐
Chest Pain	☐	☐
Circulatory problems	☐	☐
Cold Sores/Fever Blisters	☐	☐
Congenital Heart Disorder	☐	☐
Convulsions	☐	☐
Cortisone Treatments	☐	☐
Cough, Persistent or bloody	☐	☐
Dental Anxiety	☐	☐
Diabetes	☐	☐
Drug Use/Addiction	☐	☐
Easily Winded	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Excessive thirst	☐	☐
Eye Problems	☐	☐
Fainting or dizziness	☐	☐
Frequent/Severe Headaches	☐	☐
Glaucoma	☐	☐
Heart Attack	☐	☐
Heart Disease	☐	☐
Heart Murmur	☐	☐
Hemophilia	☐	☐
Hepatitis Type_____	☐	☐

	Yes	No
Herpes	☐	☐
High Blood Pressure	☐	☐
Hives or Rash	☐	☐
Immune Deficiency	☐	☐
Irregular Heartbeat	☐	☐
Jaundice	☐	☐
Kidney Problems	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Lung Disease	☐	☐
Mental Disorder	☐	☐
Mitral Valve Prolapse	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Parathyroid Disease	☐	☐
Psychiatric Care	☐	☐
Radiation Treatments	☐	☐
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shingles	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Slow Healing Wounds	☐	☐
Stroke	☐	☐
Swelling of limbs	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Weight Loss Unexplained	☐	☐
Have you ever had any serious illness not listed above?	☐	☐

_____

_____

Do you use tobacco? Yes No

Circle all that apply:

Cigarettes Cigars Pipe Snuff
E-Cigarettes/Vape Chew/Dip Other

Continued (turn over)

Please list other medications you are taking, including vitamins, natural medicines, herbal supplements or remedies.

Prescriptions and Over-The -Counter Medications			
Name of Medication	Dose	Name of Medication	Dose

Preferred Pharmacy Name_____
Location_____**Phone**_____

Do you have any of the following dental concerns (Please circle all that apply)

Pain in or around your ears	Swelling	Bleeding Gums
Difficulty opening or closing	Bad Taste	Bad Breath
Difficulty chewing	Food Catching	Tooth Pain
History of trauma to jaw or face	Clenching	Grinding
Diagnosis of TMJ/TMD	Clicking in jaw joint	Other: _____

Any sensitivity to the following: Hot Cold Sweets Biting

1.	Are you having tooth or gum pain at this time?	Yes	No
2.	Do you feel nervous about having dental treatment?	Yes	No
3.	Have you ever had a bad experience in a dental office?	Yes	No
4.	Do your gums bleed when brushing / flossing?	Yes	No
5.	Have you ever seen a periodontist?	Yes	No
6.	Have you ever had a "deep cleaning" (Scaling and Root Planing)?	Yes	No
7.	Is there anything you would like to speak with the Doctor about in private?	Yes	No
8.	Would you be interested in discussing ways to improve your smile?	Yes	No
	If yes, please explain: _____		

New patients only

Date of last dental exam:_____ Date of last dental x-rays: _____
Previous dentist's name / location:_____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____ _____
Signature of patient (or guardian if under age 18) Print Name Date

Doctor's Signature_____

Continued (turn over)