Dr. Susan D. King & Associates, P.A.

MEDICAL AND DENTAL HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Do you now have, or have you ever had any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Anaphylaxis	☐ Yes ☐ No
Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Hart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No	Breathing Problems	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold Sores/Fever Blister	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No	Heart pacemaker	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	STI's	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No	Prosthetic Heart Valve	☐ Yes ☐ No	Organ Transplant	☐ Yes ☐ No
Eye Disease	☐ Yes ☐ No	Infective Endocarditis	☐ Yes ☐ No	Neurological Problems	☐ Yes ☐ No	Ear Trouble	☐ Yes ☐ No

Have you ever had any illness/condition not listed above? ☐ Yes ☐ No If yes:

Are you allergic to any of the following?

Latex	☐ Yes ☐ No	Aspirin	☐ Yes ☐ No	Codeine	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Sulfa Drugs	☐ Yes ☐ No	NSAIDS	☐ Yes ☐ No	Mycin Drugs	☐ Yes ☐ No	Local Anesthetics	☐ Yes ☐ No

Do you have any other drug allergies? ☐ Yes ☐ No If yes:

Are you under a physician's care now?	☐ Yes ☐ No	If yes:	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes:	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes:	
Are you taking any medications, pills or drugs?	☐ Yes ☐ No	If yes:	
Have you ever taken Fosamax, Boniva, Actonel or any other Medications containing bisphosphonates?	☐ Yes ☐ No	If yes:	
Are you on a special diet?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		

When was you last dental appointment?	Date:	Do you have a click or pain in the jaw joints?	☐ Yes ☐ No
Have you had x-rays within the last year?	☐ Yes ☐ No	Do you have any missing teeth?	☐ Yes ☐ No
Are you nervous about having dental care?	☐ Yes ☐ No	Do your gums bleed?	☐ Yes ☐ No
Do you brush daily?	☐ Yes ☐ No	Have you ever had gum treatments or gum surgery?	☐ Yes ☐ No
Do you floss daily?	☐ Yes ☐ No	Do you like the appearance of your teeth?	☐ Yes ☐ No
Are you having ant dental pain/sensitivity, or does it hurt to bite or chew?	☐ Yes ☐ No	If yes, explain:	

Do you have a family history of any of the following? These systemic conditions are known to be linked to Periodontal Disease.

Heart Disease? ☐ Yes ☐ No	High Blood Pressure? ☐ Yes ☐ No	Diabetes? ☐ Yes ☐ No	Periodontal Disease? ☐ Yes ☐ No

WOMEN are you …..

Pregnant/Trying to get pregnant? ☐ Yes ☐ No	Nursing? ☐ Yes ☐ No	Taking Oral Contraceptives? ☐ Yes ☐ No

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

Signature of Patient, Parent or Guardian:	Date: