Patient's Name: _____

MEDICAL AND DENTAL HISTORY

Enriquez Dental
Family and Cosmetic Dentistry

We ask the following medical and dental history questions to ensure safe treatment. Please answer all questions. Keep us informed of any changes in your health.

Have you ever had any of the following?

	Yes	No			Yes	No	
1			Are you in good health?	27			X-ray treatment for cancer?
2			Do you take any medicine, pills or drugs? List:	28			Glaucoma or eye trouble?
3			Are you currently under treatment by a physician? Please explain.	29			Do you wear contact lenses or glasses?
4			Have you ever had an unusual reaction or are you **ALLERGIC** to any medication? (Penicillin, Latex, Codeine, Novocain, Aspirin) List:	30			Hearing trouble?
				31			Nervous problems?
				32			Mental Illness?
5			A serious illness or operations? List:	33			Do you smoke?
6			Limited motion, trouble walking, sitting, or lying down?	34			Syphilis, Gonorrhea or other Venereal Disease?
7			Artificial Prosthetics?	35			Women: Are you pregnant?
8			High or low blood pressure	36			Are you bothered by tooth or gum sensitivity (cold, heat, pressure)?
9			Any blood or bleeding problem?	37			Are you on a diet?
10			Anemia?	38			Do you have any problem eating, Chewing or swallowing?
11			**RHEUMATIC FEVER?**				
12			**HEART MURMUR?**	39			Do your gums ever bleed?
13			Pacemaker?	40			Have you ever had any injury to your face or jaws?
14			**HEART DISEASE?**	41			Do you grind or clench your teeth?
15			Valvular Replacements?	42			Does your jaw ever get "out of joint", click or pop?
16			Frequent Headache?	43			Are you aware of any swellings, rashes, lumps, sore, or white patches in your mouth?
17			Epilepsy?	44			Are you unhappy with your smile?
18			Circulation problems?	45			Do you need instructions for brushing and flossing?
19			Hepatitis, Jaundice, or Liver disease?	46			Do you fear dental treatment?
20			Tuberculosis or lung disease?	47			Have you ever had braces or orthodontics?
21			Asthma, Hay Fever, Sinus trouble?	48			Root canal therapy?
22			Diabetes?	49			Gum Treatment?
23			Arthritis?	50			Bite Adjustment?
24			Thyroid Disease?	51			Nitrous Oxide (Laughing Gas)?
25			Cancer?	52			Been put to sleep for dental treatment?
26			Tumor or Growth?	53			**HIV positive or AIDS?**

Please add any additional information about your medical and dental health that might aid in your treatment.

_____

Patient or Guardian Signature _____ Date: _____

Doctor's Signature _____ Date: _____