

Loudoun Dental Smiles

Medical History

Patient's Name _____ Physician's Name _____

1. Are you under any medical treatment? Yes No
a. Have you been hospitalized in the last 2 years? Yes No
b. Have you had any serious illness in your lifetime? Yes No

Explain: _____

2. Are you currently taking **prescription medications** and for what: Yes No
Please list: _____

3. Do you have any allergies? List: _____ Yes No

4. Have you had any **allergic reactions** to drugs or anesthetic? Yes No

Penicillin ___ **Aspirin** ___ **Codeine** ___ **Sulfa** ___ **Novocain** ___ **Other** _____

5. Have you taken corticosteroids or blood thinners including aspirin recently? Yes No
Which and for how long? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING

- | | |
|--|---|
| <input type="checkbox"/> Heart murmur, Mitral valve prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart attack/surgery | <input type="checkbox"/> Liver disease (Hepatitis C) |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Artificial heart valve or joints | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers or Intestinal disorders |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma, Emphysema, Respiratory disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Arthritis or Rheumatism |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Chemo or Radiation therapy |
| <input type="checkbox"/> Autoimmune diseases | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Latex sensitivity |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug or Alcohol abuse |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Nervousness/Anxiety |

Have you ever had any swelling or serious injury to the mouth, head or neck area? Yes No

Do you use tobacco products? Yes No

Women: Are you: pregnant _____ nursing _____ taking birth control _____ reached menopause _____

NOTES: _____

I understand the above information is necessary in to provide safe, effective dental care. I have answered the questions to the best of my knowledge. I understand I am responsible for all cost of dental treatment. I authorize this office to administer such medications and perform such diagnostic/therapeutic procedures as may be necessary.

Signature: _____ Date: _____