Catalina Dental Medical/Dental History

Please Complete the Following *Confidential* Medical/Dental History Information

Patient Name: _____ **Date:** _____

Primary Care Physician: _____ Dr. Phone #: _____

Medical Specialist: _____ Dr. Phone #: _____

Are you under ongoing Medical Care now? **YES NO** For what condition: _____

Any Surgery/Hospital visit within the last 3 years? **YES NO** Please explain Procedures/Conditions:

Do you take an **antibiotic pre-medication** prior to dental visits? **YES NO** Name of Medication: _____

Please List ALL **Medications/Supplements** you currently take: _____

Have you ever taken Bone Density Drugs? (Fosamax, Boniva, etc) **YES NO** Drug Name/How Long? _____

Please **circle** any medications/materials you are **Allergic** to?

Anesthetics Latex Penicillin Sulfa Aspirin Metals Codeine

List any other **Allergies**: _____

Do you use tobacco and/or controlled substances? If yes, list type and frequency: _____

Have you ever had abnormal/prolonged bleeding? _____

For Women Only: Please Circle Yes or No: Pregnant - YES NO / Nursing - YES NO / Taking Oral Contraceptives? - YES NO

Please circle YES or NO for *each item* that you have now or have had before:

AIDS/HIV Positive	YES	NO	Cortisone	YES	NO	Hemophelia	YES	NO	Rheumatic Fever	YES	NO
Alzheimer's	YES	NO	Diabetes	YES	NO	High Blood Pressure	YES	NO	Rheumatism	YES	NO
Anemia	YES	NO	Drug Addiction	YES	NO	High Cholesterol	YES	NO	Shingles	YES	NO
Angina	YES	NO	Emphysema	YES	NO	Hypoglycemia	YES	NO	Sickle Cell Disease	YES	NO
Arthritis/Gout	YES	NO	Epilepsy / Seizures	YES	NO	Irregular Heartbeat	YES	NO	Sinus Trouble	YES	NO
Artificial Joint	YES	NO	Fainting / Dizziness	YES	NO	Kidney Problems	YES	NO	Spina Bifida	YES	NO
Asthma	YES	NO	Frequent Cough	YES	NO	Leukemia	YES	NO	Stomach Disease	YES	NO
Blood Disease	YES	NO	Frequent Diarrhea	YES	NO	Liver Disease	YES	NO	Stroke	YES	NO
Blood Transfusion	YES	NO	Glaucoma	YES	NO	Low Blood Pressure	YES	NO	Swelling of Limbs	YES	NO
Bruise Easily	YES	NO	Heart Attack/Failure	YES	NO	Lung Disease	YES	NO	Thyroid Disease	YES	NO
Cancer _____	YES	NO	Heart Murmur	YES	NO	Mitral Valve Prolapse	YES	NO	Tuberculosis	YES	NO
Chest Pains	YES	NO	Heart Pacemaker	YES	NO	Osteoporosis	YES	NO	Tumors or Growths	YES	NO
Cold Sores	YES	NO	Heart Disease	YES	NO	Parkinson's	YES	NO	Ulcers	YES	NO
Congenital Heart Disorder	YES	NO	Heart Valve (Artificial)	YES	NO	Psychiatric Care	YES	NO	Any Condition Not Listed:		
Convulsions	YES	NO	Hemophelia	YES	NO	Radiation / Chemo	YES	NO			
COPD	YES	NO	Hepatitis Type____	YES	NO	Renal Dialysis	YES	NO			

Please list family members who have had the following:

Diabetes _____

Gum Disease _____ **Cancer** _____ **Type** _____

Heart Disease _____

Do your gums bleed while brushing or flossing? **YES NO**

Are your teeth sensitive to hot/cold or sweet/sour? **YES NO**

Are you experiencing any dental pain right now? **YES NO**

Have you ever had any neck, neck, or jaw injuries? **YES NO**

Do you clench or grind your teeth? **YES NO**

Do you experience clicking/popping/pain in your jaw? **YES NO**

Date of your last dental visit: _____

Do you wear dentures or partials? Yes No How Old?____ Yrs

Do you any sores or lumps in your mouth? **YES NO**

Do you have frequent headaches? **YES NO**

Have you had orthodontic treatment? **YES NO**

Have you recently lost or gained weight? **YES NO**

Are you happy with your smile? **YES NO**

Please inform us of any special needs during dental treatment: _____

Comments: _____

Doctor Initials: _____

I certify that I have responded to the above information and to the best of my ability. I understand that providing incorrect information can be dangerous to my health. I will notify this office of any changes in my health or medications.

Signature of Patient (If patient is a minor, Signature of Guardian) Date