Time 11:42 AM

Clayton Dental Office

Medical/Dental History(Copy)

Date 1/10/2018

Patient Name: Birth Date: Date Created:

Are you currently under a physician's care? ◯ Yes ◯ No If yes

Have you ever been hospitalized/ had any surgery? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes

Do you use tobacco? ◯ Yes ◯ No If yes

Are you allergic to any of the following:

☐ Penicillin ☐ Acrylic ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Aspirin ☐ Foods ☐ Other

Women: Are you . . .

☐ Pregnant ☐ Trying to get pregnant ☐ Taking oral contraceptives

Sleep Apnea

Have you ever been diagnosed with Sleep Apnea? ◯ Yes ◯ No

If yes, do you use a CPAP machine? ◯ Yes ◯ No

Do you experience any of the following:

☐ Excessive Snoring ☐ Poor Sleep ☐ Daytime Sleepiness ☐ Acid Reflux

Dental Conditions

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

Pain in Jaw Joints	◯ Yes ◯ No	Periodontal Disease	◯ Yes ◯ No
Sensitivity	◯ Yes ◯ No	Grinding/Clenching Teeth	◯ Yes ◯ No

Are you happy with the way your teeth look? ◯ Yes ◯ No

If no, what would you like to change? omment

Heart Disease

Do you now or have you ever had the following:

Angina	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Pacemaker/Defibulator	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No

Blood Disease/Illness

Do you now or have you ever had the following:

AIDS/HIV	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Hemophilia	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No

Pulmonary Disease/Illness

Do you now or have you ever had the following:

Asthma	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	COPD	◯ Yes ◯ No

Miscellaneous

Do you now or have you ever had the following:

Alzheimers Disease	◯ Yes ◯ No	Radiation	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
Fainting/Dizziness spells	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Autism	◯ Yes ◯ No	ADHD/ADD/ODD	◯ Yes ◯ No

Have you ever had an illness/medical condition not listed above? omment

Comments:

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 my clinicians) health. It is my responsibility to inform my provider of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Relationship to Patient