CRESCENT DENTAL MEDICAL HISTORY

PATIENT_____ ***DOB***_____
Physician's Name_____ ***LAST PHYSICAL EXAM:***_____
Physician's Ph#:_____ ***Physician's Email:***_____
Previous Dentist's Name:_____ ***LAST DENTAL EXAM :***_____
Dentist's Ph#:_____ ***Dentist's Email:***_____

Are you currently or have been under the care of a physician? ***YES NO***
If so, what is the condition being treated?_____

Have you ever been told to take antibiotics prior to dental treatment? ***YES NO***
If yes, for what reason?_____

CURRENT MEDICATIONS. Please List all Current Medications & the Reason for the medication.

- ***Rx:***_____ ***Reason:*** _____
- ***Rx:***_____ ***Reason:*** _____
- ***Rx:***_____ ***Reason:*** _____
- ***Rx:***_____ ***Reason:*** _____
- ***Rx:***_____ ***Reason:*** _____
- ***Rx:***_____ ***Reason:*** _____

Are you allergic to any medications or substances? ***YES NO***
If yes, please List Them: _____
_____

Do you have any other allergies or hives? ***YES NO***

Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ***YES NO***
If yes, please List Them:_____

Are you sensitive to any metals or latex? ***YES NO***

Are you pregnant or suspect you may be? If yes, DELIVERY DATE: _____ ***YES NO***

Are you nursing? ***YES NO***

Are you taking birth control medication? Rx:_____ ***YES NO***

Have you ever been treated for, or been told you might have heart disease? ***YES NO***

****Do you have a pacemaker or an artificial heart valve implant?*** ***YES NO***

****Have you ever been told that you were born with congenital heart disease?*** ***YES NO***

Have you ever had rheumatic fever? ***YES NO***

Are you aware of any heart murmurs? ***YES NO***

Have you ever had radiation treatment or chemo therapy treatment for tumor growth or other conditions? ***YES NO***

Do you have inflammatory disease such as arthritis or rheumatism? ***YES NO***

Do you have any artificial joints/prosthesis? ***YES NO***

Do you have any blood disorders such as anemia, leukemia, etc? ***YES NO***

Have you ever bled excessively after being cut or injured? ***YES NO***

Do you have any stomach problems? ***YES NO***

Do you have any kidney problems? ***YES NO***

Do you have any liver problems? ***YES NO***

Are you diabetic? ***YES NO***

Do you have High or Low Blood Pressure? ***YES NO***

Do you have fainting or dizzy spells? ***YES NO***

Do you have asthma? ***YES NO***

Do you have epilepsy or seizure disorders? ***YES NO***

Do you have venereal disease? ***YES NO***

Have you tested HIV positive? ***YES NO***

Do you have AIDS? ***YES NO***

Have you had, or do you test positive for hepatitis? ***YES NO***

Do you, or have you had tuberculosis (TB)? ***YES NO***

Do you smoke, chew, use snuff, or any other forms of tobacco? ***YES NO***

Do you consume alcoholic beverages? ***YES NO***

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

Do you have any disease, or condition, or problem not listed? ***YES NO***
If yes, please explain:_____

Is there anything else we should know about your health that we have not covered on this form? ***YES NO***
(If yes, please explain)_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

SIGNATURE_____ ***DATE***_____
PATIENT/GUARDIAN