North County Dental Group
Patient's Medical Information

Patient's Name____ **Date of Last Physical Exam**______________

Physician's Name____**Physician's Phone #**________________

Patient's Medical History

1. Are you under medical treatment now? ....YES NO
   If so what? ____
2. Have you been hospitalized for any surgical operations or serious illness?...YES NO
   If so what?____
3. Are you taking any medicines including non-prescription medicine? …………..YES NO
   If so what? ____
4. Have you ever taken Phen-Fen or Redux?...YES NO
5. Are you taking a blood thinner?____ YES NO
6. Are you taking Boniva or any other medication for osteoporosis?____YES NO

ALLERGIES TO MEDICINES

Are you allergic to or have you had any reactions to the following?

☐ **NO KNOWN ALLERGIES** ☐ Local Anesthetics (i.e. Novocain) ☐ Penicillin/Amoxicillin ☐ Sulfa Drugs ☐ Barbiturates ☐ Sedatives
☐ Ibuprofen ☐ Aspirin ☐ Latex ☐ Codeine
☐ Other____

Please check the boxes, if you have or have had any of the following.

- ☐ Joint Replacement
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Heart Attack/Heart Disease
- ☐ Cardiac Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Angina/Chest Pains
- ☐ Rheumatic Fever
- ☐ Hepatitis/Jaundice
- ☐ Fainting/Seizures
- ☐ Asthma
- ☐ Respiratory Problems
- ☐ Epilepsy/Convulsions
- ☐ Leukemia
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Tumors or Growths
- ☐ Anemia
- ☐ Emphysema
- ☐ Cancer/Radiation Therapy
- ☐ Kidney/Liver Disease
- ☐ Venereal Diseases or STD's
- ☐ Stomach Troubles/Ulcers
- ☐ Intestinal Disease
- ☐ Stroke
- ☐ Hay Fever/Allergies
- ☐ Tuberculosis
- ☐ Recent Weight Loss
- ☐ Weight Reduction Surgery
- ☐ Night Sweats accompanied by weight loss or cough
- ☐ Wound that healed slowly or presented other complications
- ☐ AIDS / HIV Infection
- ☐ Have you ever been treated for Alcohol or
- ☐ Chemical dependency How long ago_____________________

Women Only

☐Pregnant or think you may be pregnant ☐Nursing ☐Taking Birth Control Pills

Patient Dental History

1. Do you have pain in or near your ears?.................................... .YES NO
2. Have you ever been told you have TMJ problems?......................YES NO
3. Do you ever have any unhealed injuries or inflamed
   areas in or around your mouth?..YES NO
4. Have you ever experienced any growths
   or sore spots in your mouth?...YES NO
5. Do you grind or clench your teeth during the night or day?…....YES NO
6. Does any part of your mouth hurt when clenched?.....................YES NO
7. Have you ever had any difficult extractions or have prolonged
   bleeding following extractions?..YES NO
8. Do your gums bleed?..YES NO
9. Have you ever had instructions on the care of your gums...........YES NO
10. Do you chew on only one side of your mouth?..........................YES NO
11. Do you at the present time have any dental complaints?
    If so what?..YES NO
    ____
    ____
12. Is any part of your mouth or teeth sensitive to; pressure, biting,
    hot, cold, or sweets……………………………….....………… YES NO
    If so what and where?____
    ____
13. **When was your full mouth series of X-rays taken?**________________
    Where____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor once I have been informed of any fees associated with these procedures. I also authorize the doctor to provide any and all forms of treatment, medication, and therapy that may be indicated. I am aware that it is my responsibility to inform Rancho San Diego Dental of any changes in my health or personal information.

Patient's/Guardian's Signature____**Date:**__________________

Dentist's Signature____**Date:** __________________

Doctor's Comments:____
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