Keep Smiling
THE RODDY DENTAL GROUP

Patient Medical History

Name _____ _____ _____

Age _____ **Today's Date** ____/____/____

Please respond carefully and in great detail so that we may provide you with the best care available

Physician or Medical Specialists: Phone #

_____ ____-____

_____ ____-____

_____ ____-____

Most Recent Dentist(s)

_____ ____-____

Are you currently being treated for any medical condition? ☐ Yes ☐ No

Have you ever had any of the following? ☐ Yes ☐ No

- ☐ Any Heart Ailment
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Artificial Heart Valve
- ☐ Cardiac Pacemaker
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Anemia or Leukemia
- ☐ Other Blood Disorder
- ☐ Angina or Chest Pain
- ☐ Donor Organs
- ☐ Joint Replacement Procedure
- ☐ Any Physical Disability
- ☐ Osteoporosis or Osteopenia
- ☐ Asthma
- ☐ Respiratory Ailment
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Any Kidney Disorder
- ☐ Tumors or Growths
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Any Stomach Problems
- ☐ Digestive Tract Problems
- ☐ GERD, Reflux or Heartburn
- ☐ Arthritis
- ☐ Any Type Implant
- ☐ Glaucoma
- ☐ Drug or Alcohol Dependency
- ☐ Diabetes
- ☐ Endocrine Disorder
- ☐ Any Thyroid Disorder
- ☐ Hepatitis
- ☐ Any Liver Disorder
- ☐ AIDS / HIV
- ☐ Any Sexually Transmitted Disease
- ☐ Any Neurological Condition
- ☐ Skin Disorders
- ☐ Epilepsy or Seizures
- ☐ Mental or Psychological Condition
- ☐ Any Surgical Procedure
- ☐ Any Other Medical Condition
- ☐ _____

Doctor's Notes

Please respond appropriately to the following questions and provide specific details below:

- ☐ Yes ☐ No Are you currently taking any prescription drugs or medications ?
- ☐ Yes ☐ No Do you take any over-the-counter medications, or supplements ?
- ☐ Yes ☐ No Have you had any adverse response to any medication ?
- ☐ Yes ☐ No Have you been informed that you are allergic to any medication?
- ☐ Yes ☐ No Are you allergic to any other known substance ?
- ☐ Yes ☐ No Have you had any type of operation or ever been hospitalized ?

WOMEN:

- ☐ Yes ☐ No Are you pregnant or do you believe you may be pregnant?
- ☐ Yes ☐ No Are you nursing?
- ☐ Yes ☐ No Are you taking oral contraceptives / birth control pills?

Allergies or Sensitivities:	Reaction:

Current Medications:	Dosage and Frequency:	Reason/Diagnosis:

Hospitalizations or Surgeries:	Date:

Dental History

- ☐ Yes ☐ No Do you have any specific dental problems today?
- ☐ Yes ☐ No Have you previously received detailed instruction on oral hygiene, brushing, and flossing?
- ☐ Yes ☐ No Do you avoid certain areas of your mouth?
- ☐ Yes ☐ No Have you had any head, neck, or jaw injuries?
- ☐ Yes ☐ No Have you had periodontal therapy or surgery?
- ☐ Yes ☐ No Have you had orthodontic treatment?

  Doctor_____City, State_____

  Dates of Treatment _____

- ☐ Yes ☐ No Do you have any sores or lumps in or about your mouth or neck?
- ☐ Yes ☐ No Do you have clicking in your jaw joint?
- ☐ Yes ☐ No Do you clench or grind your teeth?
- ☐ Yes ☐ No Do you experience frequent headaches?
- ☐ Yes ☐ No Do you have difficulty opening widely?
- ☐ Yes ☐ No Have you been treated for TMJ disorder?
- ☐ Yes ☐ No Have you had any adverse reactions to any local anesthetics (Novocaine, etc.)?