Time 10:39 AM | Paluxy Dental Group PC | Date 1/18/2019

MEDICAL HISTORY AND CONSENT

Patient Name: | Birth Date: | Date Created:

Although dental personnel treat the area in and around your mouth, your mouth is part of your entire body. Health conditions or problems that you have or had, or medications that you may be tal

ALLERGIES

☐ Acrylics	☐ Anaphalaxis	☐ Latex	☐ Local Anesthetics
☐ Penicillin	☐ Metal	☐ Sulfa Drugs	

Other: ☐ If yes

CARDIOVASCULAR

Artificial Heart Valve	◯ Yes ◯ No	Coronary Artery Disease	◯ Yes ◯ No	Chest Pain or Angina	◯ Yes ◯ No	Congestive Heart Failure	◯ Yes ◯ No
Heart Attack	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Irregular Heart Beat	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No
Tachycardia	◯ Yes ◯ No						

ENDOCRINE

Diabetes	◯ Yes ◯ No	Gout	◯ Yes ◯ No	Hormonal Change	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No

EYES, EARS, NOSE and THROAT

Change in Hearing	◯ Yes ◯ No	Change in Vision	◯ Yes ◯ No	Dysphagia	◯ Yes ◯ No	Ear Pain	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Nasal Obstruction	◯ Yes ◯ No	Nose Bleeding	◯ Yes ◯ No
Sinus Problems	◯ Yes ◯ No	Tonsillectomy	◯ Yes ◯ No	Tinnitus (Ringing)	◯ Yes ◯ No		

GASTROINTESTINAL

Acid Reflux	◯ Yes ◯ No	GERD	◯ Yes ◯ No	Soft or Special Diet	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No

GENITOURINARY

Frequent Urination	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Nocturia	◯ Yes ◯ No		

GENERAL

Cancer	◯ Yes ◯ No	Fatigue/Tired	◯ Yes ◯ No	General Weakness	◯ Yes ◯ No	Headaches	◯ Yes ◯ No
HIV/AIDS	◯ Yes ◯ No	Knee/Hip Replacement	◯ Yes ◯ No	Liver Problems	◯ Yes ◯ No	Recent Trauma or Injury	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No	Weight Change	◯ Yes ◯ No		

HEMATOLOGICAL

Bleeding Problems	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No				

ORAL

Bleeding Gums	◯ Yes ◯ No	Dry Mouth	◯ Yes ◯ No	Jaw Problems (TMJ)	◯ Yes ◯ No	Orthodontic/Invisalign	◯ Yes ◯ No
Periodontal Disease	◯ Yes ◯ No	Teeth Clenching	◯ Yes ◯ No	Teeth Grinding	◯ Yes ◯ No	Tooth Pain	◯ Yes ◯ No
Wisdom Teeth Extracted	◯ Yes ◯ No	Do you wear removable teeth?	◯ Yes ◯ No	Do you take a premed?	◯ Yes ◯ No		

MUSCULOSKELETAL

Back Pain	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Joint Pain	◯ Yes ◯ No		

NEUROLOGICAL

Alzheimer's Disease	◯ Yes ◯ No	Dizziness	◯ Yes ◯ No	Fainting	◯ Yes ◯ No	Memory Loss	◯ Yes ◯ No
Multiple Sclerosis (MS)	◯ Yes ◯ No	Muscle Weekness	◯ Yes ◯ No	Seizures	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Tingling/Numbness	◯ Yes ◯ No	Trigeminal Neuralgia	◯ Yes ◯ No	Tremor	◯ Yes ◯ No		

PSYCHIATRIC

ADD/ADHD	◯ Yes ◯ No	Anxiety	◯ Yes ◯ No	Chemical Dependency	◯ Yes ◯ No	Depression	◯ Yes ◯ No
Eating Disorders	◯ Yes ◯ No	Excessive Stress	◯ Yes ◯ No	Memory Problems	◯ Yes ◯ No		

RESPIRATORY

Asthma	◯ Yes ◯ No	Bronchitis	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Chest Pressure	◯ Yes ◯ No
Congestion	◯ Yes ◯ No	Dyspnea (shortness of breath)	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Orthopnea	◯ Yes ◯ No
Pnemonia	◯ Yes ◯ No	Pulmonary Embolism	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No		

SLEEP

Daytime Sleepiness	◯ Yes ◯ No	Morning Headaches	◯ Yes ◯ No	Obstructive Sleep Apnea	◯ Yes ◯ No	Do you use a CPAP?	◯ Yes ◯ No
Do you snore?	◯ Yes ◯ No						

SOCIAL HISTORY

Do you smoke?	◯ Yes ◯ No	Do you use smokeless tobacco?	◯ Yes ◯ No	Do you consume alcholoic beverages?	◯ Yes ◯ No	Do you use recreational drugs?	◯ Yes ◯ No

Are you taking any medications?	◯ Yes ◯ No	If yes	
Have you had surgery or been hospitalized?	◯ Yes ◯ No	If yes	
Do you have any medical conditions or history not listed above?	◯ Yes ◯ No	If yes	
Primary Physician's Name:	◯ Yes ◯ No	If yes	
Are you under the care of other physicians?	◯ Yes ◯ No	If yes	

Signature of Patient, Parent or Guardian:

X

Date: _____