ATLANTA LASER DENTISTRY
MEDICAL HISTORY

Patient Name____ Date: __________

If you are completing this form for another person, what is your name and relationship to that person?
Name____ Relationship______________
Emergency Contact ______________________ Relationship __________ Phone __________

It is important that we know health problems you have and medications you are taking so that we may provide you the best possible dental care. Please answer the following questions.

___Yes ___No Are you now under the care of a physician?
If yes, please indicate the reason.____

Name of physician_____________________________Phone:______________________
___Yes ___No Have you ever been hospitalized or had a major operation? When?______________
___Yes ___No Do you have active tuberculosis?
___Yes ___No Do you have a cough that produces blood?
___Yes ___No Have you had an orthopedic joint replacement? When?_____________________
___Yes ___No Do you have any condition requiring premedication with antibiotics before treatment?__________
What condition?____
WOMEN: Are you or could you be pregnant? ___Yes ___No ___Don't know. Nursing? ___Yes ___No.

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes No ?
__ __ __ Abnormal bleeding
__ __ __ AIDS or HIV infection
__ __ __ Anemia
__ __ __ Arthritis
__ __ __ Rheumatoid arthritis
__ __ __ Asthma
__ __ __ Respiratory problems, **specify:**
____
__ __ __ Cancer
__ __ __ Chemotherapy or Radiation therapy
__ __ __ Cardiovascular disease; **if yes, specify:**
____
__ __ __ Heart Attack or heart trouble; **specify:**
____
__ __ __ Blood pressure: High or Low **Circle One**
__ __ __ Pacemaker
__ __ __ Stroke
__ __ __ Mitral valve prolapse or heart murmur
__ __ __ Chest pain upon exertion
__ __ __ Diabetes
__ __ __ **Type I**___ (insulin dependent) or___**Type II**
__ __ __ Thyroid Problems: Hyper or Hypo **Circle One**
__ __ __ Hemophilia
__ __ __ Dry mouth
__ __ __ Hepatitis, jaundice, or liver disease
__ __ __ Recurrent infections, **if yes, specify:**
____

Yes No ?
__ __ __ Kidney problems
__ __ __ Mental disorders; **if yes, specify:**
____
__ __ __ Night sweats
__ __ __ Neurological or psychological disorders;
specify: ____________________________
____
__ __ __ Persistent swollen glands in neck
__ __ __ Severe headaches/migraines
__ __ __ Sexually transmitted disease
__ __ __ Swelling of any of the limbs
__ __ __ G. E. reflux or persistent heartburn
__ __ __ Eating disorder; **if yes, specify:**
____
__ __ __ Gastrointestinal disease
__ __ __ Fainting spells or seizures
__ __ __ Venereal disease
__ __ __ Systemic lupus erythematosus
__ __ __ Rheumatic Fever
__ __ __ Pain in the jaw joints TMJ/TMD
__ __ __ Shingles
__ __ __ Ulcers
__ __ __ Blood Transfusion
__ __ __ Epilepsy
__ __ __ Scarlet fever
__ __ Do you wear a removable full or partial denture?

Do you have any disease, condition, or problem not listed above that you think we should know about? __________
Please explain: ____

On a scale of one to ten, what is your level of dental anxiety? ________
What do you fear the most about dental treatment? ______________________________________

Approximately when was your last dental exam and cleaning? _____________________________

Should we request x-rays from your former dentist? _____ Please provide his/her name and phone number:

Name:_________________________________ Phone: ____________________________

ARE YOU ALLERGIC, OR HAVE YOU EVER HAD A REACTION TO ANY OF THE FOLLOWING?

Yes No ?

__ __ __ Local anesthetics: novocaine, xylocaine, etc.
__ __ __ Aspirin
__ __ __ Ibuprofen
__ __ __ Penicillin
__ __ __ Erythromycin
__ __ __ Any other antibiotics**; if yes, specify:**____________________
__ __ __ Barbiturates, sedatives, or sleeping pills; **if yes, specify:**____________________
__ __ __ Sulfa drugs
__ __ __ Codeine, or other narcotics; **if yes, specify:**____________________
__ __ __ Latex
__ __ __ Iodine
__ __ __ Pollens, or do you have seasonal hay fever
__ __ __ Foods; **if yes, specify:**____________________
__ __ __ Metals; **if yes, specify:**____________________
__ __ __ Any other substance; **if yes, specify:**____________________

If you answered yes to any allergy questions, please specify the type of reaction you had:
____

___Yes ___No Are you taking, or have you recently taken any prescription or non-prescription medicine(s)?
If yes, what medicine(s) are you taking, or have you recently taken? **List Them Below**
Please include the dosage and frequency of each.
Prescribed drugs: ____________________
____
Over the counter drugs: ____________________
____

___Yes ___No Are you taking any vitamins, natural or herbal preparations and/or food supplements?
If yes, please list: ____________________

___Yes ___No Are you taking, or have you recently taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or phen-fen (fenfluramine-phentermine combination)?

___Yes ___No Do you drink alcoholic beverages? If yes, how much did you drink within the last 24 hours?
____

___Yes ___No Are you alcohol or drug dependent? If yes, have you received treatment? __Yes __No

___Yes ___No Do you use drugs or other substances for recreational purposes? If yes, please list:
____

___Yes ___No Do you use tobacco (smoking, chewing, or snuff)? If yes, how interested are you in stopping?
__________Very interested __________Somewhat interested __________Not interested

___Yes ___No Do your gums bleed when you brush or floss?
___Yes ___No Have you ever had periodontal (gum) treatment?
___Yes ___No Are your teeth sensitive to hot, cold, sweets or pressure?
___Yes ___No Have you ever had orthodontic treatment (braces)?
___Yes ___No Do you wear a removable dental appliance (night or athletic guard)?
___Yes ___No Have you had a serious/difficult problem associated with any previous dental treatment?
Please explain:
____

We would like to know the main purpose for your visit today, and please share with us your expectations:
____
____
____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient/legalguardian____________________**Date:**__________

Signature of Dentist____________________**Date:**__________