MEDICAL & DENTAL HEALTH HISTORY

Mark B. Whaley, D.D.S.

Aesthetic & General Dentistry

All information submitted is strictly private and confidential. All information must be received prior to your initial appointment with the doctor. Please ask for assistance if you do not understand, or need clarification of, any part of this form. There are 4 pages that comprise this complete form. Please write on the reverse side of any page if you need to add or clarify any information.

Patient Name: _____ _____
LAST FIRST MIDDLE (Preferred Name)

Social Security #: _____ Birth Date: _____

Phone Numbers: Home: _____ Work: _____
Mobile: _____

Primary Physician: _____ Phone Number: _____

Address: _____
Street

_____
City State Zip Code

Preferred Pharmacy: _____ Phone Number: _____

HEALTH HISTORY

	Yes	No	Unsure
1. Do you consider yourself to be in good health?	☐	☐	☐
2. Has there been any change in your general health within the past year?	☐	☐	☐
If "Yes", please describe: _____			
3. Are you currently being treated for any medical condition?	☐	☐	☐
If "Yes", please describe: _____			
4. Have you been treated for any medical condition within the past 3 years?	☐	☐	☐
If "Yes", please describe: _____			
5. Has it been more than 3 years since your last physical examination?	☐	☐	☐
6. When was your last medical visit? _____			
7. Have you ever had a serious illness, operation, or been hospitalized?	☐	☐	☐
If "Yes", please describe: _____			
8. Do you have any allergies?	☐	☐	☐
If "Yes", please list them below:			
a) Medications: _____			
a) Latex/rubber products: _____			
a) Other (foods, hay fever): _____			
9. Have you ever had a peculiar or bad reaction to any medicines or injections?	☐	☐	☐
If "Yes", please describe: _____			

HEALTH HISTORY (continued)

	Yes	No	Unsure

10. During the last 6 months, have you taken or are you taking any medications, non-prescription drugs or herbal supplements of any kind? _____ ☐ ☐ ☐

Conditions	Drug	Dosage	Frequency Used

11. Are you on a special diet? _____ ☐ ☐ ☐

12. Have you lost or gained more than ten pounds during the last year? _____ ☐ ☐ ☐

13. Do you use tobacco products? _____ ☐ ☐ ☐

If "Yes", please indicate:

☐ Cigarettes? How many per day? _____ How many years? _____

☐ Cigars? How many per week? _____ How many years? _____

☐ Pipe smoking? How many per week? _____ How many years? _____

☐ Chewing Tobacco How often? _____ How many years? _____

14. Do you have, or have you had any of the following diseases or conditions: ☐ ☐ ☐

(Circle any that apply)

a)

Cardiovascular disease	Angina	Chest Pain
Heart Trouble	Heart Attack	Coronary Insufficiency
High or Low Blood Pressure	Heart Surgery	Coronary Occlusion
Heart Murmur	Irregular Heart Beat	Coronary Angioplasty
Mitro Value Prolapse	Stroke	Arteriosclerosis
Congenital Heart Defect	Congestive Heart Failure	Rheumatic Fever/Scarlet Fever

If "Yes", please describe the disease/condition: _____

_____

_____

b) Shortness of breath? Require extra pillows at night? _____ ☐ ☐ ☐

c) Respiratory conditions (asthma, tuberculosis, emphysema, persistent cough) ☐ ☐ ☐

If "Yes", please describe: _____

_____

e) Abnormal bleeding associated with previous surgery or trauma ☐ ☐ ☐

f) Blood disorder (Example: anemia or hemophilia) _____ ☐ ☐ ☐

g) Bruise easily _____ ☐ ☐ ☐

h) Fainting or dizzy spells _____ ☐ ☐ ☐

i) Epilepsy, seizures, or convulsions _____ ☐ ☐ ☐

j) Diabetes _____ ☐ ☐ ☐

k) Hypoglycemia (Low Blood Sugar) _____ ☐ ☐ ☐

l) Liver disease; Jaundice; or Hepatitis _____ ☐ ☐ ☐

Type of Hepatitis: _____

HEALTH HISTORY (continued)

	Yes	No	Unsure
m) Kidney or bladder trouble _____	☐	☐	☐
n) Thyroid disorder (Hypothyroid, Hyperthyroid, Goiter, Thyroid removed) __	☐	☐	☐
o) Organ transplant _____	☐	☐	☐
p) Arthritis or inflammatory rheumatism (painful swollen joints) _____	☐	☐	☐
q) Joint replacement (i.e.: hip, knee) _____	☐	☐	☐
If "Yes", describe which joint and when: _____			
_____			
r) Cancer _____	☐	☐	☐
If "Yes", area diagnosed and treatment(s) administered: _____			
_____.			
s) Psychiatric conditions _____	☐	☐	☐
t) HIV/AIDS _____	☐	☐	☐
u) Sexually transmitted disease (i.e. Syphilis, Gonorrhea, or Chlamydia) _____	☐	☐	☐
If "Yes", describe:_____			
_____.			
v) Herpes (Cold Sores) _____	☐	☐	☐
w) Alcohol, drug or chemical dependency _____	☐	☐	☐
x) Trauma or injury to the head or neck _____	☐	☐	☐
If "Yes", describe when and where: _____			
_____.			
15. Have you had any X-Rays (dental or medical) taken in the last year? _____	☐	☐	☐
If "Yes", describe when / where: _____			
_____.			
16. Have you received X-Ray or radioactive isotopes for treatment of disease? _____	☐	☐	☐
17. Do you have, or have you had, any other condition not mentioned above? _____	☐	☐	☐
If "Yes", please specify: _____			
_____.			

Female Patients Only

18. Are you pregnant or suspect you may be pregnant? _____	☐	☐	☐
If "Yes", when is your due date? _____.			
19. Are you taking birth control pills? _____	☐	☐	☐
20. Are you taking hormone replacement therapy? _____	☐	☐	☐
21. Are you taking Oral or IV-administered Bisphosphonates (Fosamax, Boniva, etc.) ?	☐	☐	☐

DENTAL HISTORY

22. Have you ever been advised to take antibiotics before any dental treatment? _____	☐	☐	☐
23. Have you had prolonged bleeding following extractions in the past? _____	☐	☐	☐
24. Are there any growths or sore spots in your mouth? _____	☐	☐	☐
25. Have you ever been diagnosed with periodontal disease, gum disease, pyorrhea? ___	☐	☐	☐
26. Do you ever have a dry or burning mouth? _____	☐	☐	☐

HEALTH HISTORY (continued)

	Yes	No	Unsure
27. When was your last dental visit? _____ What was done? _____			
28. When was your last dental cleaning or periodontal maintenance? _____			
29. Have you ever had instructions on caring for your teeth and periodontal tissues? ___	☐	☐	☐
30. Have you ever been diagnosed with or treated for Periodontal Disease? _____	☐	☐	☐
31. Have you ever had a allergic reaction to Local Anesthetic ("freezing")? _____	☐	☐	☐
32. Is any part of your mouth sore due to clenching and/or grinding? _____	☐	☐	☐
33. Have you had any difficult extractions in the past?_____	☐	☐	☐
34. Do you have difficulty opening your mouth?_____	☐	☐	☐
35. Do you have any current dental concerns/problems? _____	☐	☐	☐

If "Yes", please specify: _____

_____.

Additional Health History Information / Comments:

_____

_____

_____.

Please initial each statement, sign and date below.

____ I certify that I read, write, and speak English.

____ I certify that I have read and fully understand the terms and words within this document, the *MEDICAL & DENTAL HEALTH HISTORY*.

____ I have accurately, truthfully and completely answered the questions on this form to the best of my knowledge.

____ I understand that it is my responsibility to inform the dental office of changes in my medical status.

____ I understand that providing inaccurate or incomplete information may be hazardous to my health.

_____ _____

Patient's signature (or Responsible party/Parent/Guardian) **Date**

MARK B. WHALEY, D.D.S.
Aesthetic & General Dentistry

www.**WhaleyDDS**.com * 205 Ward Circle, Suite 2, Brentwood TN 37027 * (615) 373-4242