

Confidential Medical History
 St. Johnsbury Dental Associates, Inc.

Date: _____

Name _____ Date of birth _____ Social Security # _____
 Marital Status: married _____ single _____ divorced _____ spouse name _____
 Mailing Address _____ Town _____ State _____ ZIP _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Employer _____
 Person responsible for this account: _____
 Whom may we thank for referring you? _____
 Reason for this dental visit _____
 Date of last dental cleaning _____
 Previous dentist _____ Physician _____

The following information is requested to enable us to give you the most consideration for your time and well being. This information, important for our records and your health, is confidential. Items 1-14 below will not be entered into our computer. Please fill in the following information completely.

Please indicate as appropriate:	NO	YES	Comments
1. Are you having pain or discomfort at this time?	[]	[]	_____
2. Do you feel nervous about dental treatment?	[]	[]	_____
3. Have you had an unpleasant experience in a dental office?	[]	[]	_____
4. Are you under the care of a medical doctor now?	[]	[]	_____
5. Are you taking any medications now?	[]	[]	List: _____
6. Are you allergic to penicillin or other drugs?	[]	[]	_____
7. Do you require a premedication of any kind before dental treatment?	[]	[]	_____

Please answer yes or no to the following:

NO YES	NO YES	NO YES	NO YES
[] [] Angina	[] [] Emphysema	[] [] AIDS	[] [] Diabetes
[] [] Heart Attack/Disease	[] [] Tuberculosis	[] [] Anemia	[] [] Pain in Jaw Joints
[] [] Heart Failure	[] [] Chronic Cough	[] [] Sickle Cell Anemia	[] [] Gum (Perio) Surgery
[] [] Heart Surgery	[] [] Asthma	[] [] Hemophilia	[] [] Bleeding Gums
[] [] Artificial heart valve(s)	[] [] Cold Sores	[] [] Blood Transfusion(s)	[] [] Sinus Problems
[] [] Heart pacemaker	[] [] Drug Addiction	[] [] Bruise/Bleed Easily	[] [] Psychiatric Treatment
[] [] Heart Murmur	[] [] Alcohol Addiction	[] [] Cancer/Tumor	[] [] Depression/Anxiety
[] [] Rheumatic or Scarlet Fever	[] [] Smoke/Chew Tobacco	[] [] Chemo Therapy	[] [] Fainting/Dizzy Spells
[] [] High Blood Pressure	[] [] Hepatitis A	[] [] Radiation Therapy	[] [] Epilepsy/Seizure Disorder
[] [] Stroke	[] [] Hepatitis B	[] [] Allergies/Hives	[] [] Artificial Joints
[] [] Congenital heart lesions	[] [] Hepatitis C	[] [] Hay Fever	[] [] Arthritis
[] [] Thyroid Disease	[] [] Venereal Disease	[] [] Migraine Headaches	[] [] Allergy to Latex
[] [] Kidney Problems	[] [] Tested for AIDS	[] [] Cortisone Medicine	
[] [] Ulcers	[] [] HIV+	[] [] Glaucoma	

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|---|---------|
| 8. Do you have any disease or condition not listed above? | NO YES |
| | [] [] |
| 9. Do you have any problems that you would like to discuss with me personally? | [] [] |
| 10. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? | [] [] |
| 11. Do your ankles swell during the day? | [] [] |
| 12. Do you use more than two pillows to sleep? | [] [] |
| 13. Have you lost or gained more than 10 pounds in the last year? | [] [] |
| 14. <u>Women:</u> Are you pregnant? _____ Due Date: _____ | |

Authorization is granted for necessary dental service.

To the best of my knowledge, all of the preceding answers are true and correct. I understand that my personal physician may be contacted if there are questions or concerns about my medical history. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail. Use other side if necessary.

 Signature of Patient, Parent or Guardian