Today's Date:_____

MEDICAL HISTORY

Patient Name :_____ Date of Birth:_____

Phone #:_____ Email Address: _____

Physician:_____Phone #:_____Date of Last Physical:_____

DO YOU OR HAVE YOU EVER HAD: (circle)

1) Hospitalization for illness or surgery in last 5 years ..... Yes No
2) An allergic reaction ..... Yes No
3) Any allergic reaction:
   a. Aspirin ..... Yes No
   b. Penicillin ..... Yes No
   c. Erythromycin ..... Yes No
   d. Tetracycline ..... Yes No
   e. Codeine ..... Yes No
   f. Sedative or sleeping pills ..... Yes No
   g. Dental anesthetic ..... Yes No
   h. Latex ..... Yes No
   i. Any other Medication ..... Yes No
   _____ .
4) Blood transfusion ..... Yes No
5) Hepatitis Type___Date_____ ..... Yes No
6) Anemia or other blood disorders ..... Yes No
7) Diabetes Type _____ ..... Yes No
8) Prolonged bleeding ..... Yes No
9) High blood pressure ..... Yes No
10) Low blood pressure ..... Yes No
11) A Stroke ..... Yes No
12) Chest pains on mild exertion ..... Yes No
13) Heart trouble ..... Yes No
14) Heart murmur ..... Yes No
15) Pacemaker ..... Yes No
16) An artificial valve ..... Yes No
17) Emphysema ..... Yes No
18) Shortness of breath ..... Yes No
19) Asthma ..... Yes No
20) Hives, skin rash, hay fever ..... Yes No
21) Tuberculosis ..... Yes No
1) Epilepsy ..... Yes No
2) Seizures ..... Yes No
3) Arthritis ..... Yes No
4) An artificial joint ..... Yes No
5) Rheumatic fever ..... Yes No
6) Scarlet fever ..... Yes No
7) Kidney disease ..... Yes No
8) Liver disease ..... Yes No
9) Thyroid or parathyroid disorders ..... Yes No
10) Abdominal ulcers ..... Yes No
11) Jaundice (yellow skin and eyes) ..... Yes No
12) Arteriosclerosis ..... yes No
13) Emotional problems ..... Yes No
14) Tension or anxiety ..... Yes No
15) Tumor, growth, or cancer ..... Yes No
16) Radiation treatment ..... Yes No
17) Glaucoma ..... Yes No
18) AIDS(Acquired Immune Deficiency) Yes No
19) AIDS related diseases ..... Yes No
20) Herpes ..... Yes No
21) History of drug or alcohol abuse ..... Yes No

ARE YOU:

1) Being treated for an illness ..... Yes No
2) Now taking any medication ..... Yes No
3) Aware of change in health ..... Yes No
4) Often thirsty ..... Yes No
5) Often exhausted and fatigued ..... Yes No
6) Subject to frequent headaches ..... Yes No
7) Smoker, or any other tobacco ..... Yes No
8) Generally a nervous person ..... Yes No
9) Unhappy or depressed ..... Yes No
10) Taking any naturopathic meds ..... Yes No

IF FEMALE, ARE YOU NOW:

1) Pregnant or nursing ..... Yes No
2) Taking birth control or hormones ..... Yes No

DENTAL HISTORY

1) Are you dissatisfied with the appearance of your teeth? ..... Yes No
2) Do you have sensitive teeth? ..... Yes No
3) Do you now have bleeding gums? ..... Yes No
4) Difficulty in opening your mouth? ..... Yes No
5) Sore spots or growths in mouth? ..... Yes No
6) Prolonged bleeding after extraction? Yes No
7) Do you grind your teeth? ..... Yes No
8) Do you snore? ..... Yes No
9) Do you have sleep apnea? ..... Yes No
10) Stress or anxiety at the dentist? ..... Yes No
11) Experience TMJ problems? ..... Yes No

PLEASE CONTINUE TO THE OTHER SIDE →

PLEASE EXPLAIN FULLY IF YOU HAVE ANSWERED YES TO ANY PREVIOUS QUESTIONS

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IF THERE IS ANY CHANGE IN MY MEDICAL HISTORY, I WILL NOTIFY MY DENTIST

Patients Signature_____ **Today's Date**_____

SOUNDVIEW

Family Dental

Eric D. Kitts, DDS