MADISON FAMILY DENTISTRY

GENERAL & COSMETIC

LANCE D. DILLON, M.S., D.M.D.

Patient Last Name:_____ Patient First Name_____

DENTAL HISTORY: Date of last visit_____Date of last dental x-rays_____

Reason for today's visit_____

Former Dentist_____ Any trouble from previous dental care? Yes/No

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? Yes/No

Please circle if you have ever had:

Bad Breath	Yes/No	Blisters on lips or mouth	Yes/No
Cigarette, pipe, cigar	Yes/No	Head, Neck, jaw pain	Yes/No
Burning sensation on tongue	Yes/No	Lip or cheek biting	Yes/No
Smokeless tobacco	Yes/No	Clench or grind teeth	Yes/No
Food collection between teeth	Yes/No	Growths or sore spots in mouth	Yes/No
Gums swollen, tender, bleeding	Yes/No	Loose Teeth or broken fillings	Yes/No
Mouth breathing	Yes/No	Orthodontic treatment	Yes/No
Nitrous Oxide	Yes/No	Periodontal treatment	Yes/No
Sensitivity to pressure	Yes/No	Sensitivity to cold, heat, sweets	Yes/No

MEDICAL HISTORY:

Physician's Name & Address_____

Have you ever had a serious illness Yes/No If yes, describe_____

Have you ever had a blood transfusion Yes/No If yes, approx. date_____

(Women) Are you pregnant? Yes/No Due Date:_____ Birth Control Pills Yes/No

Allergies , hay fever, sinusitis	Yes/No	Headaches	Yes/No
Anemia	Yes/No	Heart murmur	Yes/No
Bleeding abnormally with surgery	Yes/No	Heart problems	Yes/No
Arthritis, Rheumatism	Yes/No	Hepatitis	Yes/No
Hospitalization	Yes/No	Herpes	Yes/No
Last episode_____		High blood pressure	Yes/No
Blood Disease, clotting disorders	Yes/No	Immune deficiency	Yes/No
Cancer	Yes/No	Jaundice	Yes/No
Chemotherapy	Yes/No	Kidney disease	Yes/No
Circulatory Problems	Yes/No	Low blood pressure	Yes/No
Cortisone treatments	Yes/No	Mitral Valve prolapse	Yes/No
Cough, persistent or bloody	Yes/No	Osteoporosis	Yes/No
Diabetes	Yes/No	Pacemaker	Yes/No
Emphysema	Yes/No	Radiation treatments	Yes/No
Epilepsy	Yes/No	Respiratory disease	Yes/No
Fainting	Yes/No	Rheumatic Fever	Yes/No
Glaucoma	Yes/No	Scarlet fever	Yes/No
Shortness of breath	Yes/No	Sinus trouble	Yes/No
Sickle cell anemia	Yes/No	Skin Rash	Yes/No
Slow healing wounds	Yes/No	Stroke	Yes/No
Swelling of feet and hands	Yes/No	Thyroid problems	Yes/No
Tonsilitis	Yes/No	Tuberculosis	Yes/No
Tumor or growth on head/neck	Yes/No	Ulcer	Yes/No
Venereal disease	Yes/No	Weight Loss unexplained	Yes/No
Do you wear contacts?	Yes/No	Allergic to Penicillin	Yes/No
Allergic to Aspirin	Yes/No	Allergic to other drugs?_____	

List medications you are taking_____

I have read and answered the above to the best of my Knowledge.

Signature of Patient or Guardian_____ Date_____

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