OLDROYD FAMILY DENTISTRY

MEDICAL HISTORY

Physicians Name: ______________________ Phone Number: ______________

Please list all medications: ______________________________

Pharmacy: ______________________ Phone number: ______________________

WOMEN ONLY: Are you currently pregnant? Yes No How many months? _______

Are you taking birth control? Yes No

Allergies- please circle if you're allergic to any of the following:

Aspirin	Local Anesthetics	Codeine/other narcotics
Latex Sensitivity	Penicillin	Other Antibiotic______________
Ibuprofen	Sulfa Drugs	Other______________

Do you have, or have you had any of the following? (please circle)

AIDS/HIV positive	Congenital Heart Disease	Mitral Valve Prolapse
Alzheimer's Disease	Diabetes, Type I or Type 2	Neck Ache
Anaphylaxis	Emphysema	Pacemaker
Artificial Heart Valve	Epilepsy or Seizures	Radiation Treatments
Artificial Joint:	Dizziness	Sickle Cell Disease
Hip	Glaucoma	Sinus Trouble
Knee	Headaches	Smoking/Tobacco Use:
Other	Hearing Loss	How many years_____
Asthma	Heart Concerns	Snoring
Bell's Palsy	Heart Murmur	Stroke
Bleeding disorder	Hepatitis: Type _____	Thyroid Disease
Cancer	High Blood Pressure	Trigeminal Neuralgia
Chemotherapy	Kidney Problems	Tuberculosis

Do you have, or have you had any disease, condition or problem not listed?

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DENTAL HISTORY

Are you nervous about seeing a dentist? Yes No

If yes, please tell us why: ______________________________

How often do you brush? ______________ How often do you floss? ______________

Please circle each that applies to you

Clenching	Headaches	Jaw Popping
Difficulty Chewing	I wear a night guard	My gums bleed
Difficulty Swallowing	I've had braces	My breath concerns me
Dry Mouth	Interested in whitening	Previous gum surgery
Food packs between my teeth	Interested in orthodontics	Sensitive teeth
Grinding	Jaw Pain	