Eugene F. Anderson, D. D. S. 13010 Fuller Ave., Grandview, MO 64030

MEDICAL HISTORY

Patient Name ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry you will receive. Thank you for answering the following questions.

General Physician ______________________ Physician Phone # ______________________

Are you under medical treatment now? ☐ Yes ☐ No Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No
If yes, please list ______________________________

Have you ever taken Phen-Fen/Redux? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Are you allergic to or have you had any reactions to the following?

Local Anesthetic (e.g. Novocaine)	☐ Yes	☐ No
Penicillin or any other Antibiotics	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Any Metals (e.g. nickel, mercury, etc.)	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Other (please list) ______________	☐ Yes	☐ No

Do you have or have you had any of the following?

High Blood Pressure	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Fainting	☐ Yes	☐ No
Arterial Stent	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Epilepsy / Convulsions	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No	Hay fever / Allergies	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	HIV / Aids infection	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Other Conditions	☐ Yes	☐ No	Please list ______________		

Have you ever been diagnosed as having heart trouble, rheumatic fever, heart murmur, or heart flutter? ☐ Yes ☐ No
If yes, please describe ______________________________

Have you ever been told that you need antibiotic pre-medication before dental treatment? ☐ Yes ☐ No

DENTAL HISTORY

Date of Last Dental Visit ______________ Date of Last Dental Cleaning ______________

Do your gums bleed when brushing?	☐ Yes	☐ No	Are your teeth sensitive to hot or cold?	☐ Yes	☐ No
Do you have any pain in your teeth?	☐ Yes	☐ No	Are your teeth sensitive to sweet foods?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No	Have you ever had orthodontic treatment?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No	Have you ever had a deep cleaning?	☐ Yes	☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No
If yes, please explain ______________