SMILE CENTER DENTAL (512) 452 8200 SMILES of Round Rock

Medical History Form Date_____

Patient Information

Patient's Name:_____
Last First Middle Initial

Social Security Number_____ Sex M F Date of Birth_____ Age_____

If Patient is a Minor, give Parent or Guardian's Name _____

Responsible Party Information

Last Name_____ First _____ Middle _____ Marital Status_____
Address_____ _____City_____ State_____ Zip _____
Social Security Number_____ Home Phone _____Work Phone_____ Email Address_____
Date of Birth _____ Relationship to Patient_____
Employer _____Occupation _____No. of years Employed _____
Name/Address/Phone No. of nearest relative not living with you _____

Health History Information

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care.
All information you provide will be kept confidential.

Reason for today's dental visit _____

Date of last dental visit _____Reason _____

Are you apprehensive about dental treatment? YES NO If yes, please explain_____

Are your teeth sensitive to hot, cold, sweets, pressure? YES NO Do your gums bleed, feel tender or irritated? YES NO

Are you happy with the appearance of your teeth? YES NO Do you generally tolerate dental treatment well? YES NO

Date of last check up by physician? _____ Have there been any changes in your health in the past year? YES NO

Are you under a physician's care? YES NO If so, for what?_____

Physician's name and phone number? _____

Have you ever had any serious illness, operations or hospitalizations? YES NO

If so, describe and give date? _____

IF FEMALE, are you pregnant, trying to get pregnant or any change you might be pregnant? YES NO

Are you breast feeding? YES NO Are you taking birth control? YES NO Are you taking hormonal replacement? YES NO

Do you have hay fever, frequent skin rashes, etc.? YES NO

Are You Taking or Using Any Of The Following:

Antibiotics	YES NO	Anticoagulants (blood thinners)	YES NO
Thyroid Medication	YES NO	Antihistamines, decongestants	YES NO
High Blood Pressure or Heart Medications	YES NO	Steroids	YES NO
Tranquilizers, Antidepressants	YES NO	Stomach or GI medications (antacid, etc.)	YES NO
Cholesterol reducing drugs	YES NO	Aspirin, Ibuprofen, narcotics, or other pain reliever	YES NO
Weight reduction pills or diet pills	YES NO	Vitamins, Natural remedies (ginko, ephedra, ginseng)	YES NO
Recreational drugs (marijuana, cocaine)	YES NO	Any other Medications, pills supplements or drugs	YES NO
Do you consume alcohol?	YES NO	How much per day?_____	
Do you smoke?	YES NO	How much per day?_____	For how long?_____
Do you chew tobacco?	YES NO	For how long? _____	

Are you, or have you been in a drug or alcohol recovery program? YES NO
Do you wish to talk to the doctor privately about anything? YES NO
Any additional comments?_____

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PLEASE LIST ALL CURRENT MEDICATIONS HERE _____

Are You Allergic To Or Had A Bad Reaction From:

Local anesthetic (Novocain-like drugs)	YES NO
Penicillin, Amoxicillin, Cephalosporin	YES NO
Other Antibiotics	YES NO
Barbiturates, Sedatives	YES NO
Aspirin, Ibuprofen, NSAIDS, or other pain medicines	YES NO
Codeine or other narcotics or opioids	YES NO
Latex	YES NO
Other allergies or reactions	YES NO

Please List: _____

Do You Have or Had:

Heart Murmur	YES NO
Heart Disease that was detected at birth	YES NO
Rheumatic fever or Rheumatic heart disease	YES NO
Cardiovascular disease (ches pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, Palpitations, heart surgery angioplasty, pacemaker)	YES NO
Liver disease (jaundice, hepatitis)	YES NO
Neurological Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)	YES NO
Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)	YES NO
Lunch disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)	YES NO
Kidney Disease	YES NO
Diabetes	YES NO
Thyroid Disease (hypothyroidism, tumor)	YES NO
Arthritis (which joints)	YES NO
Stomach ulcers or Intestinal problems	YES NO
Glaucoma	YES NO
Frequent or occurring mouth sores	YES NO
Implants/artificial joints anywhere in your body (heart valve, hip, knee)	YES NO
Radiation (X-Ray treatment for cancer) in head and neck region	YES NO
Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth?	YES NO
Sinus or nasal problems	YES NO
Any disease, drug or transplant operation that has depressed your immune system	YES NO
Recurrent infections of any kind	YES NO

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete an accurate

_____ _____ _____

Date **Signature of person completing Health History** **Doctor's Initials**

DO NOT WRITE BELOW THIS LINE. ***Thank you.***

Medical History Update: I have reviewed my health history dated _/_/_ and confirmed that it accurately states past and present conditions.

Exceptions _____

_____ _____ _____

Date **Signature of person completing Health Update** **Doctor's Initials**