Welcome to Gold Canyon Dentistry

MEDICAL AND DENTAL HISTORY MEDICAL

Patient Name: _____

Date of last dental visit: _____

Do you have any dental complaints?	Yes	No
Are your teeth sensitive to hot, cold, air or sweets?	Yes	No
Are you taking any medications for tooth discomfort?	Yes	No
Have you ever been pre-medicated before dental visits?	Yes	No
Do you use tobacco, drugs or alcohol?	Yes	No
Have you ever received I.V bone treatment (Zometa, Aclasta)	Yes	No
Do you take bone density prescriptions (Aredia,Fosamax,Boniva,Actonel)	Yes	No
Have you been hospitalized in the past two years?	Yes	No

If yes, explain: _____

Have you ever or do you have any of the following?

Respiratory disease	Yes	No	Breathing disorder	Yes	No
Abnormal bleeding	Yes	No	Blood disorder	Yes	No
History of cancer	Yes	No	Kidney disorder	Yes	No
Chemo/radiation	Yes	No	Thyroid disorder	Yes	No
Diabetes	Yes	No	Epilepsy	Yes	No
Artificial joints/valves	Yes	No	Cortisone treatments	Yes	No
Rheumatic fever	Yes	No	Heart problems	Yes	No
Migraines	Yes	No	Arthritis/Rheumatism	Yes	No
Hepatitis	Yes	No	Liver disease	Yes	No
Tuberculosis	Yes	No	Psychiatric problems	Yes	No
Circulatory problems	Yes	No	Clicking/pain in the jaw	Yes	No
Blood transfusion	Yes	No	Stroke	Yes	No

Allergy to antibiotics, latex, metals or medicines:	Yes	No	_____
AIDS, HIV or STD?	Yes	No	
Woman: Are you currently pregnant or nursing	Yes	No	
Mitral Valve Prolapse/Heart Mumur	Yes	No	

High or Low blood pressure? _____

Existing conditions not covered above, list current medications:

_____

_____

_____

_____

Name & Number of Primary care doctor: _____

Name & Number of Primary dental (winter visitors) _____