Shawn R. McDevitt, DDS
Dentistry for Adults and Children

## CLIENT MEDICAL HISTORY

**PATIENT NAME:** _____ **DATE** _____

Date of last dental visit _____ Name of previous Dentist _____ City _____ State _____

What dental concerns are you now having? _____

1. Are you in good health? ..... YES/NO
2. Are you pregnant or thinking you might be: ..... (Due date _____) ..... ..... YES/NO
3. Are you now or have you been under the care of a physician during the past year? ..... YES/NO
   If yes, what condition? _____
4. Are you presently taking any medications, including birth control pills? If so, name of RX/mg/condition being treated:
   a) Rx _____ mg/dosage _____ reason _____
   b) Rx _____ mg/dosage _____ reason _____
   c) Rx _____ mg/dosage _____ reason _____
   d) Rx _____ _____ mg/dosage _____ reason _____
5. Have you ever had any major injuries, illnesses, operations or medical conditions? ..... YES/NO
   a) _____ When _____
   b) _____ When _____
   c) _____ When _____
6. Have you ever had prolonged bleeding requiring treatment or are you on blood thinners? ..... YES/NO
7. Have you ever taken Bisphosphonates (Fosamax, Actonel, Boniva, etc)? Tx for osteoporosis or cancer..... YES/NO
8. **circle any of the following for which you have been treated:**

| | | | |
|---|---|---|---|
| a) rheumatic fever – heart murmur | YES/NO | l) hepatitis – serum or infectious | YES/NO |
| b) artificial heart valve – stent | YES/NO | m) exposure to the AIDS virus | YES/NO |
| c) other heart condition | YES/NO | n) high blood pressure | YES/NO |
| d) emphysema | YES/NO | o) cancer, especially of head or neck | YES/NO |
| e) diabetes | YES/NO | p) headaches | YES/NO |
| f) tuberculosis | YES/NO | q) joint replacement | YES/NO |
| g) epilepsy/convulsions | YES/NO | r) stomach problems | YES/NO |
| h) kidney liver involvement | YES/NO | s) sexually transmitted disease | YES/NO |
| i) hay fever/sinus condition | YES/NO | t) thyroid condition | YES/NO |
| j) asthma | YES/NO | u) nervousness, fainting, dizziness, depression | YES/NO |
| k) Glaucoma | YES/NO | **v) NONE OF THE ABOVE** _____ | |

9. **Circle any of the following if they have caused an unusual reaction and list all known allergies and allergic reactions:**

**WHAT WAS THE REACTION?**

a) aspirin, Ibuprofen or Tylenol: ..... _____
b) penicillin or other antibiotics ..... _____
c) dental anesthetic ..... _____
d) codeine, Valium or other sedatives . _____
e) latex or rubber products ..... _____
f) metals 0 (gold/nickel/silver)..... . _____
g) other allergies ..... _____

**NO KNOWN ALLERGIES** _____

10. Do you use tobacco? **YES/NO** If yes, circle type: smoke chew how much per day: _____ for how long: _____
11. Have you ever experienced any unfavorable reaction from previous dental treatment? ..... YES/NO
    If yes, please explain _____
12. Is your child receiving fluoride supplements? ..... YES/NO
13. What physician or hospital may we call in a medical emergency? _____
14. Emergency contact person (relationship) _____ Phone number _____

**SIGNATURE** _____ **DATE** _____