NOLA DENTAL CARE
MEDICAL INFORMATION

Print Name:____

Physician: ________________________Address: _________________________ Phone: _________

Certain illnesses and drugs make it necessary to modify our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. If you answer yes to any of the following questions below, please explain on line 26.

Have you ever had or have:

yes	no	
o	o	1. blood pressure or heart problems
o	o	2. a pacemaker, heart valve replacement, or open heart surgery
o	o	3. mitral valve prolapse, heart murmur, or rheumatic fever
o	o	4. bleeding or clotting disorders
o	o	5. do any wounds heal slowly or present complications
o	o	6. lung or breathing problems
o	o	7. asthma, emphysema, chronic sinusitis, other allergies
o	o	8. diabetes or thyroid problems
o	o	9. liver problems, hepatitis, or jaundice
o	o	10. ulcers or stomach problems
o	o	11. epilepsy or nervous disorders
o	o	12. arthritis, lupus, or artificial joint(s)
o	o	13. venereal disease, herpes
o	o	14. hiv positive or acquired immune deficiency syndrome (aids)
o	o	15. cancer, chemotherapy, x-ray therapy
o	o	16. Are you on a medically supervised or restricted diet?
o	o	17. have you been hospitalized in the past two(2) years? Date:____________Reason:______________________________
o	o	18. are you presently under the care of a medical doctor? Reason:____
o	o	19. Do you take any medicine or health supplements on a regular basis? Specify:____
o	o	20. are you allergic to penicillin, aspirin, local anesthetic, latex, or other medications/items/foods?_______________________
o	o	21. do you have any other illness, disease, or conditions not mentioned. If yes, please list:________________________________
o	o	22. any complications with previous dental treatment?
o	o	23. women: are you taking birth control pills?
o	o	24. women: are you pregnant?_____Due date:____________________
o	o	25. if yes please explain each_______________________________

DENTAL HISTORY

Do you have any present dental problems? ____

When was your last full mouth xrays taken? ______________ last cleaning/exam? ______________

Do you clench or grind your teeth or have problems with your TMJ? ______________________

Previous Dentist (Name & Location) ____

To the best of my knowledge, all of the preceding answers are true and correct and in my own hand. I will inform the doctor of all medical changes at my next appointment. I give the doctor my consent to treat my dental/oral conditions. A written medical consultation from your physician may be required before dental treatment begins.

________________   ____

Date   Signature of responsible party, parent, guardian, or patient