Eastern Shore DENTAL CARE
BILLINGS • MURPHY

Medical History

Patient's Name: _____

Are you under a physician's care now? [ ] Yes [ ] No If yes, why?: _____

_____

Please list any medications you are taking: _____

_____

Are you allergic to any medications?: _____

Do you use tobacco: [ ]Yes [ ]No

Women: Are you: Pregnant/Trying [ ]Yes [ ]No Taking Oral Contraceptives [ ]Yes [ ]No Nursing [ ]Yes [ ]No

-***PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU:***

[ ]Heart Disease	[ ]Respiratory/Lung Disease	[ ]Kidney Disease
[ ]Heart Attack	[ ]Joint Replacement	[ ]HIV Positive/AIDS
[ ]Stroke	[ ]Diabetes	[ ]Hemophilia
[ ]Blood Thinners	[ ]Cancer	[ ]Stomach Ulcers
[ ]Pacemaker	[ ]Leukemia	[ ]Hepatitis A
[ ]Artificial Heart Valve	[ ]Thyroid Disease	[ ]Hepatitis B or C
[ ]Irregular Heart Beat/Arrhythmia	[ ]High Blood Pressure	[ ]Narcotics Addiction

Please list any other serious conditions not listed here: _____

_____

Dental History

Reason for your visit today: _____ Date of last visit: _____

Date of your last dental exam/cleaning?: _____

Are you apprehensive about dental treatment? If so, why? _____

Are you happy with the appearance of your teeth? _____

Has any dental treatment been recommended but not received?: _____

What questions do you have for the doctor today?:

_____

Signed: _____ **Today's Date:** _____