HAXTUN DENTAL CARE
115 S. Colorado Ave. Haxtun, CO 80731

Medical History

Patient Name _____ DOB_____

Are you having any pain or discomfort at this time? *Yes* *No* If yes, please explain: _____
Last Dentist Visit _____ Date of Last Cleaning _____
Are you under s physician's care now? *Yes* *No* If yes, please explain: _____
Have you ever had any problems with past dental treatments? *Yes* *No* If yes, please explain: _____
Have you been hospitalized during the past two years? *Yes* *No* If yes, please explain: _____
Have you ever had a serious head or neck injury? *Yes* *No* If yes, please explain: _____
Are you currently taking any medications? *Yes* *No* If yes, please list all medications you are currently taking: _____
Are you allergic to or made sick by penicillin, aspirin, codeine, or any drugs or medications? *Yes* *No*
If yes, please explain:_____
Have you ever taken Fosamax, Bonita, Actonel or any other medications containing bisphosphonates? *Yes* *No*

Do you have, or have you had, any of the following?

Artificial Heart Valve	*Yes*	*No*	Anemia	*Yes*	*No*	Allergies or Hives	*Yes*	*No*
Heart Attack/Surgery	*Yes*	*No*	Stroke	*Yes*	*No*	Diabetes	*Yes*	*No*
Heart Murmur	*Yes*	*No*	Kidney Trouble	*Yes*	*No*	Jaundice	*Yes*	*No*
High Blood Pressure	*Yes*	*No*	Ulcers	*Yes*	*No*	Arthritis	*Yes*	*No*
AIDS/HIV +	*Yes*	*No*	Liver Problems	*Yes*	*No*	Tobacco	*Yes*	*No*
Angina Pectoris	*Yes*	*No*	Lung Disease	*Yes*	*No*	Epilepsy or Seizures	*Yes*	*No*
Rheumatic Fever	*Yes*	*No*	Cancer	*Yes*	*No*	Fainting/Dizzy Spells	*Yes*	*No*
Bleeding Problems	*Yes*	*No*	Emphysema	*Yes*	*No*	Sleep Apnea	*Yes*	*No*
Low Blood Pressure	*Yes*	*No*	Cold Sores	*Yes*	*No*	Chemotherapy	*Yes*	*No*
Heart Pacemaker	*Yes*	*No*	Tuberculosis	*Yes*	*No*	Radiation Treatment	*Yes*	*No*
Hemophilia	*Yes*	*No*	Glaucoma	*Yes*	*No*	Thyroid Disease	*Yes*	*No*
Joint Replacement	*Yes*	*No*	Hepatitis	*Yes*	*No*	Cosmetic Surgery	*Yes*	*No*
Psychiatric Treatment	*Yes*	*No*	Asthma	*Yes*	*No*	Venereal Disease	*Yes*	*No*
Nervousness/Anxiety	*Yes*	*No*	Sinus Trouble	*Yes*	*No*	Acid Reflux/GERD	*Yes*	*No*

Do you have any disease, conditions, or problems not listed above? _____
Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain, or locking open? *Yes* *No*
If yes, please explain: _____
Are you pregnant? *Yes* *No* If yes, how many month?_____ Are you nursing? *Yes* *No*
Do your gums bleed easily? *Yes* *No*
Are your teeth sensitive to hot or cold? *Yes* *No*
Would you like your teeth whiter? *Yes* *No*
Is there anything you would like to change about your smile? *Yes* *No*
If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian_____ **Date**_____