Benjamin T. Duval, DDS. LLC

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Patient Name (Last, First, Middle): _____

Date of Last Physical Exam: _____/_____/_____ Date of Last Dental Exam: _____/_____/_____

Are you now or have you recently been under a physician's care? _____ Yes _____ No
Reason: _____
Have you ever been a patient in a hospital or had any serious illness?
Explain: _____

ALLERGIES
Are you allergic to or do you suffer ill effects from any of the following?
____Penicillin ____Codeine ____ Dental Anesthesia ____ Erythromycin ____ Latex ____ Aspirin

Please list any other allergies you may have:
_____

Check any of the following that you have had or suspected:

____ Arthritis	____ Hepatitis or Jaundice	____ Bleeding Problems
____ Rheumatic Fever	____ Liver Disease	____ Fainting Tendency
____ Heart Trouble	____ Cancer or Tumor	____ Epilepsy
____ Heart Murmur	____Tuberculosis	____Thyroid Disease
____ High/Low Blood Pressure	____Diabetes	____Glaucoma
____ Chest Pain	____ Kidney/Bladder Trouble	____ Radiation Treatment
____ Stroke	____ Anemia	____ Psychiatric Disorders
____ Shortness of Breath	____ Lung Disease	____ HIV or AIDS
____ Asthma or Hay Fever	____ Venereal Disease	____ Prosthetic Joint Replacement
____ Sinus Trouble	____ Blood Disease	____ Blood Transfusion
____ Severe Head Injury	____ Emphysema	____ Ulcers
____ Bleeding Gums	____ Tooth Sensitivity	____ Popping/Clicking Jaw
____ Bad Breath	____ Past Periodontal Treatment _____	

*Have you ever been asked to **pre-medicate** before dental appointments for the following conditions?
____ Artificial Heart Valves ____Prosthetic Joint Replacement
____ Other:_____

Check any of the following that you are taking or have taken:
____ Steroids ____ Blood Thinners ____Aspirin ____ Sedatives ____ Osteoporosis medications

Are you taking any other medication? ____ YES ____ NO **<u>Please list</u>**: _____
_____
_____
_____

Women Only:
Are you pregnant? ____ Yes ____ No If yes: How many months? _____ Are you breast feeding? _____
***PLEASE NOTE: If you are taking any kind of birth control pills, shots or implants, hormone therapy, etc., please indicate these medications**

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. If there is any change in my medical status I will inform the dentist.

Signed: _____ Date:_____