NICOLE M. ARMOUR, DMD

MEDICAL AND DENTAL HISTORY

PATIENT MEDICAL HISTORY

Name:_____ Birth Date:_____
First Middle Last Month/Day/Year

Primary Physician:_____Office #:_____Last Exam Date:_____

1. Are you under medical treatment now? ☐ YES ☐ NO
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ YES ☐ NO
3. Are you taking any medication(s) including non-prescription and supplements? ☐ YES ☐ NO
   If yes, please list:_____
   _____
4. Do you use tobacco? ☐ YES ☐ NO
5. Do you use alcohol? ☐ YES ☐ NO
   If yes, how many drinks per week?_____
6. Do you use cocaine or other recreational drugs? ☐ YES ☐ NO
7. Are you allergic or have you had reactions to the following? **If NONE apply please initial here:**_____

☐ Local anesthetics (i.e. novocaine)	☐ Barbiturates
☐ Penicillin	☐ Sedatives
☐ Sulfa drugs	☐ Aspirin
☐ Other antibiotic(s)	☐ Iodine

☐ Other(s)_____

8. WOMEN ONLY:
   a. Are you pregnant or think you may be pregnant? ☐ YES ☐ NO
   b. Are you nursing? ☐ YES ☐ NO
9. Do you have, or have you had, any of the following?
   Please check all that apply. **If NONE apply, please initial here**:_____

☐ High blood pressure	☐ Asthma	☐ Recent weight loss
☐ Heart disease	☐ Seasonal Allergies	☐ HIV/AIDS
☐ Heart attack	☐ Joint replacement/Implant	☐ Liver disease
☐ Chest Pains/Angina	☐ Fainting	☐ Respiratory problems
☐ Cardiac pacemaker	☐ Thyroid problem	☐ Emphysema
☐ Heart murmur	☐ Autoimmune Disease	☐ Tuberculosis
☐ Rheumatic fever	☐ Osteoporosis/Osteopenia	☐ Kidney disease
☐ Mitral valve prolapse	☐ Diabetes Type I, Type II	☐ Glaucoma
☐ Anemia	☐ Stomach ulcers or Reflux	☐ STD
☐ Stroke	☐ Cancer	☐ Hearing impairment
☐ Seizures	☐ Radiation therapy	☐ Facial Trauma

☐ Other:_____

PATIENT DENTAL HISTORY

Please check all that apply.

☐ I have bleeding gums.	☐ I have had orthodontic work.
☐ I have gum pain.	☐ I have had wisdom teeth removed.
☐ I have tooth/teeth pain or sensitivity.	☐ I have frequent headaches.
☐ I have jaw pain.	☐ I have had head, neck, or jaw injuries.
☐ I clench or grind my teeth.	☐ I have difficulty getting numb for dentistry.

Last Dental Visit:_____

Are you happy with your smile?:_____

_____ _____/_____/_____

Signature of Patient (or parent/guardian if applicable) **Date**