Dr. Vicki L. Tibbs. D.D.S., P.C.

PATIENT MEDICAL & DENTAL HISTORY

(Please Print)

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dental care you will receive. Thank you for answering the following questions.

PATIENT NAME: _____

Are you under a physician's care now? YES ○ NO ○
If yes, please explain: _____
Name of physician: _____ Phone: _____

Have you ever been hospitalized or had a major operation? YES ○ NO ○
If yes, please explain: _____

Do you have or have you had any of the following? Please check all that apply:

- ☐ AIDS/ HIV+
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints/ Stents
- ☐ Asthma
- ☐ Cancer
- ☐ Chest Pains
- ☐ Diabetes
- ☐ Epilepsy/ Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (any)
- ☐ Herpes (any)
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Pacemaker/ Defibrillator/ Valve
- ☐ Radiation Treatment / Chemo.
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Stomach / Intestinal Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Please list any other health related conditions or serious illness not listed above:_____
_____
_____
_____

Please list **ALL MEDICATIONS,** drugs you are taking:_____
_____
_____
_____

Are you **ALLERGIC** to any of the following? :

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other: _____

WOMEN are you:

☐ Pregnant/ Trying to get pregnant ☐ Taking oral contraceptives ☐ Nursing

Comments: _____

_____

_____

_____

MEDICAL UPDATES:

Date *Medical Changes* *Patient Signature*

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

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 medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date