LIBERTY CENTER
DENTAL CARE

## Patient Medical History

Y ☐ N ☐ Abnormal bleeding after surger/injury

Y ☐ N ☐ Anemia

Y ☐ N ☐ Autoimmune disorders

Y ☐ N ☐ Bleeding easily

Y ☐ N ☐ Blood Pressure ☐ High ☐ Low

Y ☐ N ☐ Cancer

Y ☐ N ☐ Chemotherapy

Y ☐ N ☐ Chronic dryness of mouth

Y ☐ N ☐ Currently pregnant

Y ☐ N ☐ Diabetes

Y ☐ N ☐ Epilepsy

Y ☐ N ☐ Hearing impairment

Y ☐ N ☐ Heart murmur

Y ☐ N ☐ Injury to

☐ Face ☐ Neck ☐ Mouth ☐ Teeth

Y ☐ N ☐ Tumors

Y ☐ N ☐ Heart pacemaker

Y ☐ N ☐ Heart valve replacement

Y ☐ N ☐ Hepatitis

Y ☐ N ☐ Hypoglycemia

Y ☐ N ☐ Jaw joint surgery

Y ☐ N ☐ Osteoporosis

Y ☐ N ☐ Prior orthodontic treatment

Y ☐ N ☐ Stomach ulcers

Y ☐ N ☐ Stroke

Y ☐ N ☐ Tuberculosis

Y ☐ N ☐ Mouth sores

Y ☐ N ☐ Difficulty chewing

Y ☐ N ☐ Facial pain

Y ☐ N ☐ Jaw locks

Y ☐ N ☐ Limited opening of jaw

Y ☐ N ☐ Teeth not meeting properly

Y ☐ N ☐ Loss of teeth

Y ☐ N ☐ Ill-fitting dental appliance

Y ☐ N ☐ Pain in jaw joint

Y ☐ N ☐ Gag easily

Y ☐ N ☐ Head pain

Y ☐ N ☐ Jaw clicks

Y ☐ N ☐ Are you in pain? (Explain)

_____

_____

_____

Y ☐ N ☐ Kidney problems

Y ☐ N ☐ Liver disease

Y ☐ N ☐ Nervousness

Y ☐ N ☐ Neuralgia

**LIST ANY MEDICATIONS/SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION:**

Y ☐ N ☐ Antibiotics

Y ☐ N ☐ Aspirin

Y ☐ N ☐ Barbiturates

Y ☐ N ☐ Codeine

Y ☐ N ☐ Lidocaine

Y ☐ N ☐ Latex

Y ☐ N ☐ Metals

Y ☐ N ☐ Plastic

Y ☐ N ☐ Sedatives

Y ☐ N ☐ Sleeping pill

Y ☐ N ☐ Local anesthetics

Y ☐ N ☐ Other

**LIST MEDICATIONS/SUBSTANCES YOU ARE CURRENTLY TAKING:**

Y ☐ N ☐ Antibiotics

Y ☐ N ☐ Insulin

Y ☐ N ☐ Anticoagulants

Y ☐ N ☐ Muscle relaxants

Y ☐ N ☐ Barbiturates

Y ☐ N ☐ Nerve pills

Y ☐ N ☐ Blood thinners

Y ☐ N ☐ Pain medication(s)

Y ☐ N ☐ Codeine

Y ☐ N ☐ Sleeping pills

Y ☐ N ☐ Cortisone

Y ☐ N ☐ Sulfa drugs

Y ☐ N ☐ Ginko Biloba

Y ☐ N ☐ Diet pills

Y ☐ N ☐ Heart medication

Y ☐ N ☐ Tranquilizers

Y ☐ N ☐ Medications or osteoporosis

Y ☐ N ☐ Bisphosphonates

Y ☐ N ☐ Herbal supplements

Y ☐ N ☐ Other _____

**PLEASE LIST OTHER HEALTHCARE PRACTITIONERS SEEN IN THE LAST 9 MONTHS:**

| **Practitioner** | **Specialty** | **Treatment and Date** |
|---|---|---|
| | | |

| | | |
|---|---|---|
| | | |
| | | |

Do you take aspirin regularly Y☐ N☐

Smoke tobacco Y☐ N☐

Nervous disturbances Y☐ N☐

Has any close relative had a serious illness or condition?

_____

_____

**Patient Signature: _____ Date: _____**