MEDICAL HEALTH HISTORY
BROOKSTONE DENTAL

Dr. Michael A Mower Dr. Stephanie J. Mower

Name _____ SS# _____ Date of Birth ____ / ____ /____

Address _____ Gender: ❑ Male ❑ Female

City _____ State _____ Zip _____ Employer _____

Telephone (Home) _____ (Cell) _____ (Work) _____ Occupation _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's Name _____ Spouse's SS# _____ Date of Birth _____

Spouse's Employer _____ Spouse's Work Telephone _____

Name of Nearest Relative (Emergency) _____ Emergency Telephone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Height _____ Weight _____ Age _____

Date of last dental examination _____ Date of last dental x-ray _____

Name of your medical doctor _____ Date of last complete medical exam _____

Are you under medical treatment now? _____ Why? _____

What pills or medications are you presently taking? _____

_____

For what purpose? _____

_____

Have you had major surgery in the last two years? _____ What for? _____

Do you clench or grind your teeth? _____

Are you presently in dental pain? _____

Is any part of your mouth sensitive to temperature, pressure, or food or drink? What? _____

Do you currently take herbs / vitamins? Which ones? _____

Do you have headaches? How often? _____

Have you had any pains in the chest or shortness of breath? _____

Are you handicapped or disabled? _____

Have you ever had any type of radiation therapy (other than diagnostic)? _____

Do you smoke or use chewing tobacco? _____

Are you susceptible to latex allergy? _____

Have you ever take Fen-Phen? _____

Are you pregnant? _____

Are you allergic to:

	✓Yes	✓No	
Drugs	❑	❑	What? _____
Dental anesthetic	❑	❑	What? _____
Metals	❑	❑	What? _____
Other material	❑	❑	What? _____
Foods or insects	❑	❑	What? _____

Do you have or have you ever had any of the following:

	✓Yes	✓No
Abnormal blood pressure	❑	❑
Arthritis or rheumatism	❑	❑
Artificial joints	❑	❑
Asthma or hay fever	❑	❑
Blood disease or anemia	❑	❑
Chemotherapy	❑	❑
Chronic cough	❑	❑
Cold sores or fever blisters	❑	❑
Congenital heart lesions	❑	❑
Diabetes	❑	❑
Epilepsy	❑	❑
Excessive urination or thirst	❑	❑
Fainting spells	❑	❑
Frequent canker sores	❑	❑
Glaucoma	❑	❑
Head injury	❑	❑
Heart disease	❑	❑
Heart murmur	❑	❑

	✓Yes	✓No
Heart pacemaker	❑	❑
Heart prolapse mitral valve	❑	❑
Hepatitis	❑	❑
HIV / ARC / AIDS	❑	❑
Jaundice	❑	❑
Kidney disorder	❑	❑
Leukemia	❑	❑
Multiple Sclerosis	❑	❑
Osteoporosis	❑	❑
Parkinsons	❑	❑
Prolonged bleeding	❑	❑
Psychiatric treatment	❑	❑
Rheumatic fever	❑	❑
Sinus trouble	❑	❑
Stroke	❑	❑
Thyroid condition	❑	❑
Tuberculosis or lung disease	❑	❑
Tumors or growths	❑	❑
Ulcers	❑	❑

Tell your health care professional about all other medicines you are taking, including non-prescription medicines, nutritional supplements, or herbal products. Also tell your health care professional if you are a frequent user of drinks with caffeine or alcohol, if you smoke, or if you use illegal drugs. These may affect the way your medicine works.

Any other medical or health concerns that the dentist should be aware of: _____

_____

Signature _____ Date _____ Date _____