Bellflower Family Dental Services

Proudly Serving Bellflower Since 1989

Medical/Dental History

Print Name: ______________________________ Date: ___/___/___

Physicians Name: ______________ Address: ______________________

Phone #: (_____) _______-________ City: ______________ State: _____ Zip: ________

When did you last consult a physician? ______________ Reason: ______________

Have you been a patient in a hospital in the past 5 years: ☐ Yes ☐ No Reason: ______________

Have you had any serious illnesses or operations: ☐ Yes ☐ No

Name of former dentist: ______________________ Date of Last Dental Examination: ___/___/___

Do you have or have you had any of the following (Please check and describe fully under remarks if needed):

	YES	NO
16. Heart Disease	☐	☐
17. High Blood Pressure	☐	☐
18. Blood Disorder – anemia	☐	☐
19. Rheumatic Fever	☐	☐
20. Heart Murmur	☐	☐
21. Thyroid Disease		
Hyperthyroidism	☐	☐
22. Diabetes	☐	☐
23. Stroke	☐	☐
24. Epilepsy	☐	☐

	YES	NO
1. Fainting (syncope)	☐	☐
2. Psychiatric Treatment	☐	☐
3. Arthritis	☐	☐
4. Tumor History	☐	☐
5. Venereal Disease	☐	☐
6. Sinus Trouble	☐	☐
7. Ulcers	☐	☐
8. Radiation Treatment	☐	☐
9. Liver or Kidney Disease	☐	☐
10. Hepatitis, Juandice	☐	☐

	YES	NO
11. Allergies		
a. Penicillin	☐	☐
b. Other Antibiotics	☐	☐
c. Codeine, Aspirin	☐	☐
d. Local Anesthetic, Novocain	☐	☐
e. Other allergies	☐	☐
12. Asthma	☐	☐
13. Tuberculosis, Emphysema	☐	☐
14. Do you smoke?	☐	☐
15. Are you pregnant?	☐	☐

	YES	NO
25. AIDS	☐	☐
26. ARC	☐	☐
27. Have you had excessive bleeding requiring treatment?	☐	☐
28. Are you taking any medicines, drugs or pills?	☐	☐
29. Have you experienced any unfavorable reactions to previous dental treatment?	☐	☐

Allergic to Latex? YES or NO Phen-Fen-Redux use? YES or NO

Do you have any disease, condition or problem not listed above that you think the Doctor should know about?

____

____

____

Remarks:

____

____

____

Patient Signature: ______________________________ Date: ___/___/___