Poulson Family Dental
481 S 8th Ave
Brighton, CO 80601
jeffpoulson@poulsonfamilydental.com

Medical History Patient Name _____ DOB _____

Physician's Name: _____ **Address:**_____ **Phone:** _____

Are you having **pain or discomfort** at this time? ○Y ○N Please explain: _____
Do you feel **very nervous** about having dental treatment? ○Y ○N Please explain:_____
Have you ever had a **bad experience** in a dental office? ○Y ○N Please explain:_____
Have you been a **patient in the hospital** during the past **two years**? ○Y ○N Please explain: _____
Are you under the care of a medical doctor? ○Y ○N Please explain:_____
Are you taking any **prescription or over-the-counter** medications? ○Y ○N **Please list**: _____
_____
Are you taking any **dietary or natural** supplements? ○Y ○N **Please list**:_____
_____
Have you had any **excessive bleeding** requiring special treatment? ? ○Y ○N Please list: _____

Are you ALLERGIC or sensitive to any of the following:

○ **Aspirin**	○ **Codeine**	○ **Egg**	○ **Hay/Seasonal**
○ **Iodine**	○ **Latex**	○ **Metal**	○ **Nut**
○ **Penicillin**	○ **Sulfa**	○ **Other: Please list:**_____	

Circle any of the following, which you have had or have at present:

Abnormal Bleeding…….. ○Yes ○No	Emphysema…….. ○Yes ○No	Liver Disease…… ○Yes ○No
AIDS / HIV+……..…….. ○Yes ○No	Epilepsy or seizures…….. ○Yes ○No	Mental Disorders……... ○Yes ○No
Anemia……..…… ○Yes ○No	Head Injuries…… ○Yes ○No	Nervous Disorders……. ○Yes ○No
Arteriosclerosis…… ○Yes ○No	Headaches (Frequent)…... ○Yes ○No	Pacemaker…… ○Yes ○No
Arthritis…… ○Yes ○No	Heart Disease…… ○Yes ○No	Radiation Treatment…….. ○Yes ○No
Artificial Joints/Valve……... ○Yes ○No	Heart Murmur……... ○Yes ○No	Respiratory Problems…… ○Yes ○No
Asthma…….. ○Yes ○No	Hemophilia…… ○Yes ○No	Rheumatic Fever……... ○Yes ○No
Blood Disease/Transfusion….. ○Yes ○No	Hepatitis A…… ○Yes ○No	Rheumatism…….. ○Yes ○No
Bruise Easily…… ○Yes ○No	Hepatitis B…… ○Yes ○No	Sinus Problems…… ○Yes ○No
Cancer/Chemotherapy…….. ○Yes ○No	Hepatitis C…… ○Yes ○No	Stomach Problems…… ○Yes ○No
Congestive Heart Failure…….. ○Yes ○No	Hyper/Hypothyrodism…. ○Yes ○No	Stroke…… ○Yes ○No
Cortisone Medication…… ○Yes ○No	Hypertension…… ○Yes ○No	Tuberculosis…… ○Yes ○No
Diabetes…… ○Yes ○No	Hypotension…….. ○Yes ○No	Tumors…….. ○Yes ○No
Drug Addiction…… ○Yes ○No	Kidney Disease…… ○Yes ○No	Ulcers…… ○Yes ○No

Women:

Are you pregnant now? ○Y ○N **What Week:** _____ **Are you nursing?** ○Y ○N
Are you taking birth control pills? ○Y ○N **(Antibiotic medications can reduce birth control effectiveness)**
Do you anticipate becoming pregnant? ○Y ○N

When you walk up stairs or take a walk, do you ever stop because of chest pain, shortness of breath, or fatigue? …… ○Y ○N
Do your ankles swell during the day? ……..……..……..……..……..……..……..…… ○Y ○N
Do you use more than 2 pillows to sleep? ……..……..……..……..……..……..…….. ○Y ○N
Have you lost or gained more than 10 pounds in the past year? ……..……..……..……..…… ○Y ○N
Do you ever wake up from sleep with short of breath? ……..……..……..……..……..…… ○Y ○N
Are you on a special diet? ……..……..……..……..……..……..……..…….. ○Y ○N
Do you have any disease, conditions, or problems not listed? ……..……..……..……..……... ○Y ○N
If yes, please list:_____

Do you use any of the following products? (Please circle)

○ Cigarettes ○ Alcohol ○ Cigars ○ Chewing Tobacco ○ Pipe ○ Snuff

When was your last dental cleaning and exam? _____ **Where?**_____
Is there anything you would like to change about your smile? _____
_____