Medical History
Dwaine E. Valentine, D.D.S., Inc.

Patient Name______________________________ **DOB**________________

Do you have or have a history of any of the following conditions? Please check all that apply.

- ○ Angina or Chest Pain on Exertion/Heart Attack
- ○ Artificial Heart Valve or Damaged Heart Valves
- ○ Artificial Joints
- ○ Arteriosclerosis
- ○ Asthma
- ○ Autoimmune Disease
- ○ Blood Disease
- ○ Blood Transfusion Date of Transfusion __________
- ○ Cancer
- ○ Cardiovascular Disease or Circulatory Problems
- ○ Chemical Dependency
- ○ Congestive Heart Failure
- ○ Diabetes (Please circle one) Type I or Type II
- ○ Emphysema
- ○ Epilepsy/Fainting/Seizures
- ○ Glaucoma
- ○ Blood Pressure (Please circle one) High or Low
- ○ Hepatitis/Liver Disease
- ○ Kidney Disease
- ○ Sleep Disorder/Snoring/Sleep Apnea
- ○ Stroke
- ○ Thyroid Disease
- ○ Tuberculosis
- ○ Any other Condition or Illness (Please Specify)

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Are you allergic to any of the following?

- _____ Aspirin
- _____ Penicillin
- _____ Local Anesthetic
- _____ Codeine
- _____ Sulfa
- _____ Sedatives
- _____ Metals
- _____ Latex
- _____ Iodine
- _____ Other (Please Specify)

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Pregnant?__________ If so when are you due?________ Nursing? ____________

Name of Physician__________________________ Date of Last Physical ___________________

Current Medications ____

Dental History- Please check all that apply

- ○ Bad Breath
- ○ Food collection between teeth
- ○ Bleeding Gums, Gingivititis, or Previous Periodontal Treatment
- ○ Clenching/Grinding, Popping Jaw, Earaches, Neck Pains
- ○ Broken Teeth, Loose Fillings, Loose Teeth, Current Discomfort
- ○ Sensitivity to Hot, Cold, Sweets or Chewing
- ○ Growth or Sores in Mouth

Do you use tobacco (smoking, snuff, or chew) Yes_______ No________

How often do you brush?___________ How often do you floss?___________

The information given is accurate and complete to the best of my knowledge. I will not hold Dr. Valentine or any of his staff responsible for any errors I may have in completion of this form.

Signature ____ **Date** ______________

(For Future Use) After review of this form and all corrections have been made please initial and date

Initals________Date__________ Initials________Date__________ Initials____________Date___________