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

Patients Name_____ **DOB**_____

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

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

_____

Are you allergic to any of the following?

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

_____

_____

Pregnant?_____ If so when are you due?_____ Nursing? _____

Name of Physician_____ Date of Last Physical _____

Current Medications _____

Dental History- Please check all that apply

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