Marshall Dental, PLC

159 Lichfield Boulevard
Suite 107
Fredericksburg VA 22406-

www.marshalldentalva.com

(540)373-2273

marshalldentalva@gmail.com

Medical Health History

Patient Name: ______ Last ______ First ______ MI ______ Preferred Name

Are you experiencing dental pain or discomfort?

Yes No

Are you in good health?

Yes No

Has there been a change in your general health?

Yes No

Are you under the care of a physician? If so, what condition is being treated:

Name and phone number of your physician:

Name and phone number of preferred pharmacy:

FOR WOMEN ONLY- ARE YOU PREGNANT? Please indicate what month

FOR WOMEN ONLY- Are you nursing?

Yes No

FOR WOMEN ONLY- Are you taking Birth Control Pills?

Yes No

Have you been hospitalized or had a serious operation/illness in the past 5 years?

Yes No

Person to Contact in an emergency: Please name relationship home, work and cell numbers:

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Do you have/have you had any of the following disease or problems? Please check all that apply.

- [ ] Abnormal Bleeding
- [ ] Alchohol Abuse
- [ ] Allergies
- [ ] Anemia
- [ ] Angina Pectoris
- [ ] Arthritis
- [ ] Artifical Bones
- [ ] Asthma
- [ ] Blood Transfusion
- [ ] Colitis
- [ ] Cosmetic Surgery
- [ ] Diabetes
- [ ] Difficulty Breathing
- [ ] Drug Abuse
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Fainting Spells
- [ ] Fever Blister
- [ ] Frequent Headaches
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Attack
- [ ] Heart Surgery
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] HIV+/AIDS
- [ ] Kidney Problems
- [ ] Liver Disease
- [ ] Pace Maker
- [ ] Pneumocystits
- [ ] Artifical Heart Valve
- [ ] Cancer- Chemotherapy
- [ ] Congenital Heart Defects
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Mitral Valve Prolapse
- [ ] Psychiatric Problems
- [ ] Radiation Therapy
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus Problems
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Yellow Jaundice

Are you taking any drug or medicine? If So, please list:

Are you currently taking any pre-medications for any conditions?

- [ ] Pre-Med Amoxicillin
- [ ] Pre-Med Clindamycin
- [ ] Pre-Med Other

Please explain why you are taking pre-medication?

Do you have allergies or adverse reactions to any food, drug or medicine? Please mark all that apply.

- [ ] Aspirin
- [ ] Dental Anesthesia
- [ ] Jewelry
- [ ] Metals
- [ ] Tetracycline
- [ ] Codeine
- [ ] Erythromycin
- [ ] Latex
- [ ] Penicillin
- [ ] Food
- [ ] Material
- [ ] Sulfa

When you walk, do you have to stop due to pain in your chest?

◯ Yes ◯ No

Do you smoke or use alcohol?

◯ Yes ◯ No

Do you have a concern or condition not listed you think I should be aware of?

Dental Information

What is your immediate concern?

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is there anything about the appearance of your smile that you would like to change?

Previous Dentist Name and Phone Number

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth

- [ ] Food gets trapped between any teeth
- [ ] Have you ever whitened or bleached you teeth
- [ ] Have you experienced popping and/or clicking of your jaw joint
- [ ] You have difficulty chewing
- [ ] You clench or grind your teeth
- [ ] You wear or have worn a bite appliance
- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury)
- [ ] Experienced a burning sensation in your mouth
- [ ] You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe

Have you had serious trouble associated with previous dental treatment?

○ Yes ○ No

Have you had any abnormal bleeding associated with dental treatment?

○ Yes ○ No

Doctor's Notes:

By signing, I acknowldge that I have read this statement and agree to the contents.

Signature: ______________________ Date:

Response Date: