Padre DENTAL GROUP
Kaenel & Kaenel Dental Corporation
WWW.PADREDENTAL.COM

MEDICAL AND HEALTH HISTORY

Do you currently or have you ever had?

Asthma	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Allergies	Yes ☐ No ☐	Kidney or Bladder Disease	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐	Hepatitis, Cirrhosis, Liver Disease	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐
Heart Disease or Attack	Yes ☐ No ☐	Fainting or Dizzy spells	Yes ☐ No ☐
Angina Pectoris	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Blood Transfusion	Yes ☐ No ☐
Pacemaker	Yes ☐ No ☐	Abnormal Bleeding Tendencies	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐	HIV infection or AIDS	Yes ☐ No ☐
Rheumatic Fever	Yes ☐ No ☐	Sickle Cell Disease or Trait	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐	Stomach or Intestinal Ulcers	Yes ☐ No ☐
Joint Replacement	Yes ☐ No ☐	Chemo or Radiation Treatment	Yes ☐ No ☐
Prosthetic Heart Valve	Yes ☐ No ☐	Women: Pregnant or Nursing	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐	Alcoholism or Drug addiction	Yes ☐ No ☐
Thyroid Disease	Yes ☐ No ☐	History of Tobacco	Yes ☐ No ☐
Latex Sensitivity	Yes ☐ No ☐	Reaction to Dental Anesthesia	Yes ☐ No ☐
		Have you used the drug Phen-Fen	Yes ☐ No ☐

Do you have any other medical condition not already listed? _____
Physician's Name _____ Specialty _____ Phone # _____

Are you taking any medications at the present time? No ☐ Yes ☐ please list: _____

_____

Are you allergic or sensitive to any medication? No ☐ Yes ☐ please list: _____

DENTAL SPECIFIC QUESTIONS:

Do you have TMJ (jaw joint) pain?	Yes ☐ No ☐
Do you clinch or grind your teeth?	Yes ☐ No ☐
Do you currently have pain in your teeth or gums?	Yes ☐ No ☐
Are you happy with the appearance of your teeth?	Yes ☐ No ☐
Have you thought about bleaching?	Yes ☐ No ☐
Have you been to a dentist in the past year?	Yes ☐ No ☐

Name of your last dentist _____ Phone # _____

Thank you for taking the time to fill out this questionnaire. This information will be kept completely confidential.

Patient or Guardian Signature_____ **Date** ___/___/___
Doctor's Signature _____ Date ___/___/___

Updating your medical history:
Patient or Guardian Signature_____ **Date** ___/___/___
Doctor's Signature _____ **Date** ___/___/___