Mark W. Mercer, D.D.S.

CONFIDENTIAL MEDICAL AND DENTAL HISTORY FORM Date_____

PATIENT NAME_____Date of Birth_____

Dental history

Do you have a specific dental problem?_____
Do you have routine dental exams?_____
Do you ever have clicking, popping, or discomfort in your jaw?_____
Name of your previous dentist_____
Have you had a full mouth (20 or more) series of x-rays?_____

Medical history

Date of your last physical exam_____
Are you now, or have you recently been, under a physician's care?_____
Have you been hospitalized for a serious illness?_____

Check any of the following that pertain to you:

_____Pacemaker	_____Sinus trouble	_____Thyroid Disease
_____Artificial heart valves	_____Cancer or tumor	_____Glaucoma
_____Heart murmur	_____Tuberculosis	_____Radiation Therapy
_____High/Low blood pressure	_____Kidney/Bladder Trouble	_____Allergies (pollen/dust)
_____Stroke	_____Anemia	_____Allergies (medicine)
_____Shortness of Breath	_____Lung Disease	_____Alzheimer's Disease
_____Asthma	_____Venereal Disease	_____HIV or AIDS
_____Hepatitis	_____Blood Disorders	_____Artificial Joint
_____Jaundice	_____Prolonged Bleeding	_____Rheumatic fever
_____Fainting Spells	_____Epilepsy	_____Diabetic

Do you, for any medical reason, need to take a premedication (antibiotic) before having any dental procedure?_____

Do you smoke or chew?_____

Are you or have you ever taken any of the following medications?

_____Cortisone Drugs	_____Anticoagulants	_____Tranquilizers
_____Steroids	_____Blood Thinners	

Please list any medications you are taking_____

Please circle any of the following you may have allergies to:

Penicillin Sulfa Codeine Acrylic Dental Anesthesia Aspirin Erythromycin Household Bleach
Latex Other:_____

Women: (please check)_____Pregnant _____Nursing _____Taking oral contraceptives

Patient Signature:_____

Medical review by Doctor BP Date