Frank Shaw DDS 2551 N. Clark Street, Suite 500 Chicago, Illinois 60614 773.549.2881

Dental/Medical History

Patient Name_____ Birth Date_____

Dental History

Reason for today's visit_____

Please Circle "yes" or "no" to indicate if you currently have or have had a history of any of the following:

Bad Breath	yes	no	Grinding teeth	yes	no	Periodontal treatment	yes	no
Bleeding gums	yes	no	Gums tender	yes	no	Sensitivity to cold	yes	no
Blisters on lip/mouth	yes	no	Jaw pain	yes	no	Sensitivity to heat	yes	no
Broken fillings	yes	no	Lip/cheek biting	yes	no	Sensitivity to sweets	yes	no
Burning feeling in mouth	yes	no	Loose teeth	yes	no	Sensitivity when biting	yes	no
Clicking or popping jaw	yes	no	Mouth breathing	yes	no	Sores in your mouth	yes	no
Dry mouth	yes	no	Orthodontic treatment	yes	no	Tobacco use	yes	no

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions to the best of your ability.

Are you under a physician's care now? Yes No If yes, explain:_____

When was your last physical exam?_____Name of Physician:_____

Please list any prescription drugs you are taking _____

Women Only: (please circle)

Pregnant? yes no Taking Oral Contraceptives? yes no Nursing? yes no

Are you allergic or have you had a reaction to any of the following? (please circle)

Local anesthetics	yes	no	Nitrous Oxide	yes	no	Sulfa Drugs	yes	no
Aspirin	yes	no	Codeine/Narcotics	yes	no	Penicillin	yes	no
Barbiturates/sedatives	yes	no	Iodine	yes	no	Latex	yes	no

Other_____

Do you have, or have you had, any of the following? (please circle)

AIDS/HIV Positive	yes	no	Cortisone Medicine	yes	no	Hemophilia	yes	no	Renal Disease	yes	no
Alzheimer's Disease	yes	no	Diabetes	yes	no	Hepatitis A	yes	no	Rheumatic Fever	yes	no
Anaphylaxis	yes	no	Drug Addiction	yes	no	Hepatitis B or C	yes	no	Rheumatism	yes	no
Anemia	yes	no	Emphysema	yes	no	Herpes	yes	no	Scarlet Fever	yes	no
Angina	yes	no	Epilepsy/Seizures	yes	no	High Blood Pressure	yes	no	Shingles	yes	no
Arthritis/Gout	yes	no	Excessive Bleeding	yes	no	Hypoglycemia	yes	no	Sickle Cell Disease	yes	no
Artificial Heart Valve	yes	no	Excessive Thirst	yes	no	Irregular Heartbeat	yes	no	Sinus Trouble	yes	no
Artificial Joints	yes	no	Fainting/Dizziness	yes	no	Kidney Problems	yes	no	Stroke	yes	no
Asthma	yes	no	Frequent Cough	yes	no	Leukemia	yes	no	Swelling of Limbs	yes	no
Blood Transfusion	yes	no	Frequent Headaches	yes	no	Liver Disease	yes	no	Thyroid Disease	yes	no
Bruise Easily	yes	no	Glaucoma	yes	no	Low Blood Pressure	yes	no	Tonsillitis	yes	no
Cancer	yes	no	Hay Fever	yes	no	Lung Disease	yes	no	Tuberculosis	yes	no
Chemotherapy	yes	no	Heart Attack/Failure	yes	no	Mitral Valve Prolapse	yes	no	Tumors/Growths	yes	no
Chest Pains	yes	no	Heart Murmur	yes	no	Psychiatric Care	yes	no	Ulcers	yes	no
Congenital Heart Issue	yes	no	Heart Pace Maker	yes	no	Radiation Treatment	yes	no	Venereal Disease	yes	no
Convulsions	yes	no	Heart Trouble/Disease	yes	no	Recent Weight Loss	yes	no	Yellow Jaundice	yes	no

Do you have/had any serious illness not listed above? Yes No If yes, please explain:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian_____ Date_____