PACE DENTAL
on Pleasant Street
State of the Heart Dentistry

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Vienna, Virginia 22180
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www.pacedental.com

PATIENT HISTORY

To help us meet all of your dental health care needs, please complete this form as accurately as possible. Thank you.

DENTAL

What is the reason for your visit today? _____

Yes___ No___ Do you require pre-medication before dental treatment?
If yes, name of meds _____

Yes___ No___ Are you currently in pain?

Yes___ No___ Do your gums ever bleed?

Yes___ No___ Have you ever had difficulties associated with any previous dental work?

Yes___ No___ Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)?

Yes___ No___ Have your tonsils or adenoids been removed?

Yes___ No___ Do you floss on a regular basis?

MEDICAL

Yes___ No___ Do you consider yourself in good medical health?

Yes___ No___ Are you taking any medications? If yes, please list here _____
_____

Yes___ No___ Are you allergic to any medications? If yes, please list here _____
_____

Yes___ No___ (Women) Are you currently pregnant? If yes, how many weeks? _____

Yes___ No___ (Women) Are you nursing

Yes___ No___ (Women) Are you taking birth control?

Yes___ No___ Are you allergic to aspirin?

Yes___ No___ Are you allergic to codeine?

Yes___ No___ Are you allergic to dental anesthetics?

Yes___ No___ Are you allergic to erythromycin?

Yes___ No___ Are you allergic to latex or rubber products?

Yes___ No___ Are you allergic to metals?

Yes___ No___ Are you allergic to penicillin?

Yes___ No___ Are you allergic to tetracycline?

Continued on back

MEDICAL (Continued)

Have you ever had any of the following medical problems?

Yes___	No___	Abnormal bleeding	Yes___	No___	Hepatitis
Yes___	No___	Alcohol / Drug abuse	Yes___	No___	Herpes / Fever Blisters
Yes___	No___	Anemia	Yes___	No___	High Blood Pressure
Yes___	No___	Arthritis	Yes___	No___	HIV / AIDS
Yes___	No___	Asthma	Yes___	No___	Kidney Problems
Yes___	No___	Cancer	Yes___	No___	Liver Problems
Yes___	No___	Diabetes	Yes___	No___	Low Blood Pressure
Yes___	No___	Difficulty Breathing	Yes___	No___	Pacemaker
Yes___	No___	Emphysema	Yes___	No___	Rheumatic Fever
Yes___	No___	Epilepsy	Yes___	No___	Seizures
Yes___	No___	Fainting Spells	Yes___	No___	Shingles
Yes___	No___	Frequent Headaches	Yes___	No___	Sickle Cell Disease
Yes___	No___	Glaucoma	Yes___	No___	Sinus Problems
Yes___	No___	Hay Fever	Yes___	No___	Stroke
Yes___	No___	Heart Attack	Yes___	No___	Thyroid Problems
Yes___	No___	Heart Murmur	Yes___	No___	Tuberculosis
Yes___	No___	Heart Surgery	Yes___	No___	Ulcers
Yes___	No___	Hemophilia	Yes___	No___	Venereal Disease

Yes___ No___ Do you have any medical conditions not listed above?

If yes, please explain _____

_____

_____

_____

ACKNOWLEDGEMENT & AUTHORIZATION

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE _____ DATE _____