Medical History

Palmetto Health USC
MEDICAL GROUP
DENTISTRY

Date_____

Patient Information

Last Name_____ First Name_____ Middle Initial_____

What is your primary reason to see us today?_____

Are you happy with your smile? ☐ Yes ☐ No How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Are you interested in: Replacing any lost or missing teeth? ☐ Yes ☐ No Whitening your teeth? ☐ Yes ☐ No Teeth straightening? ☐ Yes ☐ No

Have there been any changes in your general health within the past year? ☐ Yes ☐ No If yes, please explain_____

_____

Have you been hospitalized or had a serious illness in the past two years? ☐ Yes ☐ No If yes, please explain_____

_____

Previous operative/invasive procedures or surgeries? ☐ Yes ☐ No If yes, please explain_____

_____

Primary care physician name and address_____

_____ Date of last physical exam_____

Medications currently taking_____

Do you use tobacco products ☐ Yes ☐ No If yes, what type/frequency?_____

Medications (Please check if you take or have taken any of the following medications within the past two [2] years)

Antibiotics	☐ Yes ☐ No	Anticoagulants (blood thinners)	☐ Yes ☐ No	Heart medications	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Bisphosphonates (Fosamax, etc.)	☐ Yes ☐ No	Inhalers	☐ Yes ☐ No
Steroids (Cortisone, Prednisone)	☐ Yes ☐ No	Blood pressure medications	☐ Yes ☐ No	If yes, what type?_____	
Prescriptions pain medications	☐ Yes ☐ No	Diabetes medications	☐ Yes ☐ No	_____	
Nitroglycerin	☐ Yes ☐ No	Supplements/herbal medications	☐ Yes ☐ No	_____	
Non-prescription medications	☐ Yes ☐ No	Anti-anxiety/antidepressants	☐ Yes ☐ No		

Please check if you have or have had any of the following diseases or problems?

High blood pressure	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No	Bleeding disorder	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Hepatitis or liver disease	☐ Yes ☐ No	Prolonged or abnormal bleeding	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Blood transfusion	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Epilepsy or seizure disorder	☐ Yes ☐ No	HIV or AIDS	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Lung disease	☐ Yes ☐ No	Leukemia or lymphoma	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Chronic sinusitis	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Seasonal allergies	☐ Yes ☐ No	Head and neck radiation therapy	☐ Yes ☐ No
Swelling of feet or ankles	☐ Yes ☐ No	Reflux or GERD	☐ Yes ☐ No	Psychiatric treatment	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	If yes, what type?_____	
Any artificial joints (hip/knee)	☐ Yes ☐ No	Sickle cell disease	☐ Yes ☐ No	_____	

Allergies (Please check if you are allergic or have adversely reacted to the following)

Local anesthetics (lidocaine)	☐ Yes ☐ No	Non-steroidals or other pain medications	☐ Yes ☐ No	Latex	☐ Yes ☐ No
Antibiotics	☐ Yes ☐ No	Sedative medications	☐ Yes ☐ No	Codeine or other narcotics	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Iodine	☐ Yes ☐ No	Other health conditions?	☐ Yes ☐ No
Shellfish	☐ Yes ☐ No	Milk products	☐ Yes ☐ No	If yes, describe_____	
				_____	

Women Only

Could you be pregnant?	☐ Yes ☐ No	Are you taking birth control pills?	☐ Yes ☐ No	Are you currently nursing?	☐ Yes ☐ No
		If yes, what kind?_____			
		_____			

Patient blood pressure_____ Patient pulse rate_____