Timothy G. Mahoney, DDS

MEDICAL HISTORY

Patient Name _____ Name you like to be called _____

Why are you here today? _____

Please list medications you are taking: _____
(Including Vitamins, Supplements, Herbs, etc.)
Medical Doctors _____

Check if you have ever had the following:

1. Allergic or Adverse Reaction to medication ☐
   - ☐ aspirin
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ local anaesthetic
   - ☐ fluoride
   - ☐ codeine
   - ☐ latex
   - ☐ metals
   - ☐ other

2. Heart Problems ☐
   - ☐ murmur
   - ☐ rheumatic fever
   - ☐ scarlet fever
   - ☐ high blood pressure
   - ☐ low blood pressure
   - ☐ stroke
   - ☐ pacemaker
   - ☐ anemia
   - ☐ prolonged bleeding

3. Communicable Diseases ☐
   - ☐ tuberculosis
   - ☐ hepatitis type _____
   - ☐ acquired immune deficiency syndrome
   - ☐ jaundice

4. Respiratory conditions ☐ asthma ☐ emphysema ☐ other ☐ use tobacco products

5. Women - Are you pregnant? Due Date _____

6. Please list any past or current medical conditions you may have that are not listed above _____

   _____

7. Jaw Problems (temporomandibular joint) ☐
   - ☐ headaches
   - ☐ difficulty opening your mouth widely
   - ☐ stiff neck muscles
   - ☐ grind your teeth
   - ☐ clench your teeth
   - ☐ jaw clicking
   - ☐ awaken with an awareness of your jaw or teeth

8. Concerns with your gums or teeth ☐
   - ☐ If you could change anything about your smile, what would it be? _____

     _____
   - ☐ bleeding gums
   - ☐ sensitive to temperature
   - ☐ sore teeth
   - ☐ unfavorable dental experiences
   - ☐ dental fears

9. Can you tell us what caused you to leave your last dental office? _____

   _____

10. What is important to you when you start going to a new dentist? _____

    _____

11. What can we do to help you feel comfortable at our office? _____

    _____

Patient's Signature _____ Date _____