X

McMullin Dental Care
Medical History
Birth Date:

Date:_____

Patient Name: Date Created:

tions you had your tonal or adenoids removed? Veal No	Although dental personnel p or medication that you may	orimarily to be taking	reat the a ,, could ha	rea in and arou we an importar	und your mou nt interrelatio	th, your monship with t	outh is a pa the dentist	art of your entire body ry you will receive.Th	y. Health nank you	proble for ans	ms that yo	ou may have, e following questions.		
tive you are need and according for child year. If year is not support on the your and advantages of the final year. If year is not support on your beauty in the your personnel of the final year. If year is not you are according for child year. If year is not your and your to the your and a special date. If year is not your and your to the your and a special date. If year is not your and your to the your and a special date. If year is not your and your to the your and a special date. If year is not your to the your and a special date. If year is not your to the your and a special date. If year is not your to the your and your cards of the final your cards of the final your cards of your your to the your and your cards of the final your cards of your your to your to your to your your to your your to your cards. If year is not your your to your to your cards of your cards of your your to your your your your your your your you	Are you under a physician's	care nov	v?		⊚ Yes	⊚ No	If yes							
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The year of the containing any membrane, all the present states of the containing and the present of the containing and the con	Have you ever had a seriou	∇os	No.	Ifvec										
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To you have a tendency for colds? The way the real a tendency for colds for				er or arry ourer	© Yes	⊚ No	IT yes							
To you have a tradeury for colde? Var No Traduct sure of tradition Trequent our principles Trequent o	Are you on a special diet?				Yes	⊚ No								
request car inflications? Tracepost or an inflications? Trac	Have you had your tonsil or	adenoid	s removed	d?	Yes	○ No								
Transport or Infectional State of the following of the fo	Do you have a tendency for	Yes	⊚ No											
comen. Acr you April Pencilla Pe	Frequent sore throats?				Yes	○ No								
Perpatual/Tyring to get pregnant? Navaring? Taking or all contraceptives? Acrylic	Frequent ear infections?				Yes	⊚ No								
Programs/Trying to get programs/P	Have you ever had tubes pl	laces in y	our ears?		Yes	⊚ No								
Agryn Percilin Codene Aryly Content Codene Aryly Codene Codene Codene Codene Codene Codene Codene Codene Codene Codene	/omen: Are you Pregnant/Trying to get p	pregnant	?		Nursin	g?				T	aking oral o	contraceptives?		
Suffa Drugs		following	1?											
Type Second Processor Second	Aspirin											_ ,		
AlbSAHV Postive AlbSAHV Postiv				Latex				Suna Drugs				Lucai Anesthétics		
Albehemer's Dianease	Other?						If yes							
Alphemer's Dileasee	o you have, or have you ha	d, any of	f the follow	ving?										
Anaphylosis	AIDS/HIV Positive	Yes	⊚ No		edicine	Yes	○ No	_	(Yes	⊚ No			
Amenia					ion							_		
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Artificial John Vers No Excessive Billededing Vers No Artificial John Vers No Famining Spellic/Inzariess Vers No Famining Spellic/Inzariess Vers No Heart Transfusion Vers No Famining Spellic/Inzariess Vers No Heart Transfusion Vers No Heart Transfusion Vers No Heart Attack/Failure Vers No Heart Attack/Failure Vers No Heart Attack/Failure Vers No Heart Transfusion Vers No Heart Transfusion Vers No Heart Transfusion Vers No Heart Attack/Failure Vers No Heart Transfusion Vers No Vers No Heart Transfusion Vers No Heart Transfusion Vers No Periodicte an answer for each behavior / habit: Vers No Dim Sunder	Angina	Yes	⊚ No	Emphysema		Yes	⊚ No	High Blood Pressure	(Yes	⊚ No	Rheumatism	Yes	⊚ No
Artificial Jont Prequent Cough Prequent Liberabea Prequent Cough Prequent Liberabea Preg No December Serve No December Serve No December Serve No December Nes No December Serve No Decem	Arthritis/Gout							_						
Aathma				1	_							_		
Blood Transfusion	Asthma													
Breathing Problems Yes No Grids Herpes Yes No Hart Attack/Fallure Yes No Hart Attack/Fallure Yes No Hart Namur Yes No Hart Namur Yes No Convulsions Yes No Convulsions Yes No Hart Trouble/Disease Yes No Psychiatric Care Yes No No Weneral Disease Yes No Hart Namur Yes No Psychiatric Care Yes No Hart Namur Yes No Psychiatric Care Yes No Hart Namur Yes No Psychiatric Care Yes No Hart Namur Yes No Hart Hard Yes Hert Namur Yes No Psychiatric Care Yes No Hart Namur Yes No Hart Namu	Blood Disease			1	_							-		
Bruise Easily														
Chemotherapy	Bruise Easily													
Chest Pains	Cancer	Yes	○ No			Yes	○ No	_					Yes	⊚ No
Cold Sresifiever Blisters					le /E sile ma									
Congenital Heart Disorder	Cold Sores/Fever Blisters													
Yellow Jaundice Yes No If yes All Habits / History All Habits	Congenital Heart Disorder			Heart Pacer	naker			Parathyroid Disease				Ulcers		
Have you ever had any serious illness not listed above? Yes No If yes all Habits / History asse indicate an answer for each behavior / habit: Grind Teeth Yes No Bite Cheek Yes No Cigar/Cigarette Yes No Cigar/Cigaret	Convulsions			Heart Troub	le/Disease	Yes	○ No	Psychiatric Care	(Yes	○ No	Venereal Disease	Yes	○ No
ral Habits / History lase indicate an answer for each behavior / habit: Grind Teeth Ves No Bullmials / Anorexia Yes No Pipe Yes No Bullmials / Anorexia Bullmials / Anorexia Yes No Cigar/Cigarette Yes No Smokeless Tobacco Yes No Chew Gum Yes N	Yellow Jaundice	Yes	⊚ No											
Asserting the season of the search behavior / habit: Grind Teeth Yes No Wouth Breather Yes No Bite Cheek Bite Nails Yes No Bite Nails Yes No Smokeless Tobacco Yes No Chew Gum Yes No Chew Gum Yes No Smokeless Tobacco Yes No No Bite Nails Yes No Chew Gum Yes No Chew Gum Yes No	Have you ever had any seri	ious illnes	s not liste	d above?	Yes	⊚ No	If yes							
Grind Teeth	ral Habits / History													
Mouth Breather		each bel												
Pipe														
Eat Candy	Pipe													
e you teeth sensitive to: Hot or Cold	Suck Thumb/Finger							Chev	w Gum					
Hot or Cold	Eat Candy		0	Yes No	Drink Soft	t Drinks		Yes	○ No					
Biting / Chewing Sweets	re you teeth sensitive to:									-				
Sweets	Hot or Cold													
Orthodontic Treatment Yes No Oral Surgery Yes No Oral Surgery Yes No Oral Surgery Played any musical intruments Yes No Oral Surgery Yes No Oral Surger	Sweets													
Orthodontic Treatment Yes No Oral Surgery Yes No Oral Surgery Yes No Oral Surgery Played any musical intruments Yes No Oral Surgery Yes No Oral Surger	ave you ever had:													
Played any musical intruments Yes No Momments: 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 nonsibility to inform the dental office of any changes in medical status.	Orthodontic Treatment		0	Yes No	A Bite Pla	te or Guard	1	⊚ Yes	⊚ No	Perio	dontic Tre	atment	⊚ Yes 《	∋ No
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 consibility to inform the dental office of any changes in medical status.	Oral Surgery				Serious Ir	njury to Mo	uth	Yes	⊚ No	Spee	ch Probler	ns	O Yes	No
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 sonsibility to inform the dental office of any changes in medical status.	Played any musical intrume	ents	(Yes No										
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gnature of Patient, Parent or Guardian:	sponsibility to inform the den	ital office	of any ch	nanges in medio	aí status.									
	ignature of Patient, Parent (or Guardi	an:											