MAGNOLIA FAMILY DENTAL
COMPREHENSIVE AND COSMETIC DENTISTRY

605 Olney-Sandy Spring Rd.
Sandy Spring, MD 20860
301-774-8555

PATIENT HEALTH HISTORY

Last Name: _____ First Name:_____ Birthdate:_____

Emergency Contact: _____Phone: _____Relationship:_____

New Patients:

Do you have Panoramic or Full Mouth x-rays that are less than 5 years old? _____
Do you have BiteWing x-rays that are less than 1 year old? _____
Have you had orthodontic treatment (braces)? _____
Do you still wear retainers? _____
Have you had your wisdom teeth removed? _____ Other oral surgery? _____

Name of former Dentist:_____ City/State: _____

Date of last cleaning and exam: _____

List all medications that you are now taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are you allergic to any of the following? (check all that apply)

Anesthetic
Aspirin
Codeine
Ibuprofen
Iodine
Latex
Penicillin
Sulfa

Other allergies not listed above:

_____

Do you have any of the following medical conditions? (check all that apply)

Asthma/Emphysema	Ulcers	Chemotherapy
Kidney Disease/Dialysis	Thyroid Disorder	Hepatitis/Liver Disorder
Bleeding Problems	Pacemaker/Defibrillator	Epilepsy or Seizures
Liver Disease	Vascular Shunt	Anorexia or Bulimia
Cancer or Tumor	Cardiac Stent	Tuberculosis/Lung
Pregnancy	Artificial Heart Valve	Disorder
Diabetes	Congenital Heart Defect	Drug Addiction
Psychiatric Treatment	HIV or AIDS	Alcohol Addiction
Heart Murmur	Migraine Headaches	Memory Issues/Dementia
Rheumatic Fever	Gastric Reflux	Blood or Bleeding
Sinus Trouble	Artificial Joint	Disorder
High Blood Pressure	Sleep Disorder	Arthritis
Stroke or T.I.A	Glaucoma	
Joint Replacement	Radiation Therapy	

Other conditions not listed above:

_____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? _____

Do you have any of the following concerns? (check all that apply)

I want whiter teeth	My teeth look too short or long
I want to eliminate the spaces between my teeth	I show too much gums when I smile
I have chipped or broken teeth	I am missing teeth in my smile
I don't like the shape of my teeth	Other:
My teeth are crowded together	_____
I have discolored crowns	_____
My gums are discolored	_____
My gums are puffy and bleed a lot	

Patient/Guardian Signature _____ Date: _____